

# The Idea of the Maternal Protection Act and Its Application: From the standpoint of Japan Association of Obstetricians & Gynecologists

JMAJ 55(3): 208–212, 2012

Toshihiko TERAO\*<sup>1</sup>

**Key words** Eugenic Protection Act, Maternal Protection Act, Illegal abortion, Maternal welfare, Induced abortion, Abortion laws

## Enactment of the Eugenic Protection Act and the Foundation of Japan Association for Maternal Welfare

Enacted in 1948 in Japan, the Eugenic Protection Act originates from the national eugenic law (also called the sterilization law) and had considerable eugenic ideology. Article 1 of this Act states its purpose that “from the eugenic point of view, it aims to prevent the birth of inferior offspring as well as to protect maternal life and health.” The association of maternal welfare was established in each prefecture, and in April of 1949, Japan Association for Maternal Welfare,<sup>\*2</sup> a professional organization composed of designated physicians under the Eugenic Protection Act, was born.

## The Progress of Japan Association of Obstetricians & Gynecologists (JAOG) over the Last 60 Years and the Maternal Protection Act

Common ideas in society change over time. With the rejection of eugenic ideology, the Eugenic Protection Act was re-titled the Maternal Protection Act, and with it Japan Association for Maternal Welfare changed its name to Japan

Association of Obstetricians & Gynecologists (JAOG). The history of JAOG is shown in **Table 1**, along with the changes in commonly accepted social ideas in Japan and the world and medical progress that relates to the Maternal Protection Act. Article 1 of the Act states, “this Act aims to protect maternal life and health by stipulating affairs regarding sterilization and induced abortion procedures.”

The very purpose of establishing JAOG requires that our main activity is the proper operation of the Maternal Protection Act. But since its establishment, JAOG has not merely been an organization that deals with induced abortion and eugenic procedures, but an organization that promotes “healthy maternal and child health-care” as stipulated in the articles. It has been over 60 years since the establishment, but this idea of JAOG has not changed, even today.

The Convention on the Elimination of All Forms of Discrimination against Women came into effect worldwide by the United Nations, and the Equal Opportunity Act was enacted in Japan. Then, the idea of “reproductive health and rights” was advocated at the International Conference on Population and Development (Cairo, Egypt; 1994) and the 4th World Conference on Women (Beijing, China; 1995). As problems unique to

\*1 President, Japan Association of Obstetricians & Gynecologists, Tokyo, Japan (yggqn324@yahoo.co.jp).

This article is a revised English version of a paper originally published in the Journal of the Japan Medical Association (Vol. 140, No.2, 2011, pages 338–341). The original paper is based on a lecture presented at “Symposium: The Idea of the Maternal Protection Act and Its Application” during FY2010 Workshop for Instructors of Family Planning and Maternal Protection Act, held at the JMA Hall on December 4, 2010.

\*2 Currently called Japan Association of Obstetricians & Gynecologists (JAOG).

**Table 1 The Progress of Japan Association of Obstetricians & Gynecologists (JAOG) over the last 60 years and the Maternal Protection Act**

Changes in common ideas in the society		Medical progress	Events of JAOG*
1948.4 to 1960.3	Eugenic Protection Act (1948) Public Assistance Act (1950) Child Welfare Act is partially revised (1950) Practical instructor system for birth control (1952)	Gestational limit for induced abortion: <8 months of pregnancy (1953)	Japan Association for Maternal Welfare (1949) Japan Association for Maternal Welfare, Incorp. (1952)
1960.4 to 1970.3	Child-care allowance is established (1961) to Maternal and Child Health Act (1965) Campaign against abortion starts (1968)	Prostaglandin agents are developed HMG agents are developed Synthetic gestagens are developed Serodiagnosis of rubella Retinopathy of prematurity	Ogyaa Donation Foundation (1964) The Japan maternal training session (Japan Maternal Meeting) starts (1964) Sectional council meeting starts (1965)
1970.4 to 1980.3	The case of Doctor Kikuta's baby adoption to service (1973) Legalization of induced abortion in foreign countries	Gestational limit for induced abortion: <24 weeks of pregnancy (1976) First successful case of in vitro fertilization and embryo transfer in the world (1978)	The 1st Sex Education Seminar (1978)
1980.4 to 1990.3	Convention on the Elimination of All Forms of to Discrimination Against Women took effect (1981) Equal Opportunity Act is enacted (1985) Special adoption system (1987)	First successful case of in vitro fertilization and embryo transfer in Japan (1983) Fetal heart rate monitoring and ultrasound diagnosis advance Ritodrine agents are developed	The specialist system by Japan Society of Obstetrics and Gynecology starts (1987)
1990.4 to 2000.3	International Conference on Population and to Development (Cairo, Egypt; 1994) The 4th World Conference on Women (Beijing, China; 1995) Maternal Protection Act (1996): Article 14 of the Eugenic Protection Act (abolition of <i>the fetus clause</i> ), eugenic procedure is revised as sterilization procedure	Gestational limit for induced abortion: <22 weeks of pregnancy (1990) Prenatal diagnosis advances	Japan Association of Obstetricians & Gynecologists For Maternal Welfare (JAOG), Incorp. (1994)
2000.4 to 2010.3	The first "Baby Post" project is approved (2007) to Compensation system for obstetric care starts (2009)	Decoding of all base pairs of human DNA is declared (2003)	Japan Association of Obstetricians & Gynecologists (JAOG), Incorp. (2001) JAOG Academic Meeting (2002)

\* JAOG = Japan Association of Obstetricians & Gynecologists.

females, two issues were addressed: 1) Women face various health issues throughout their lives that are different from men, not only pregnancy and labor but also puberty and menopause, and both mental and physical conditions as well as life situations can drastically change, and 2) Especially pregnancy and labor affect women both physically and mentally and also change their life plans considerably, and therefore, the idea of "respecting females' own decisions" should be accepted and that "females should have the right to freely and responsively decide the number of children they wish to bear and the interval between pregnancies."

As medicine advances, the gestational limit of fetal viability becomes shorter. Along with it, the gestational limit for induced abortion under the Maternal Protection Act changed from less than 8 months of pregnancy to less than 24 weeks, and at present it is revised to less than 22 weeks.

Since the enactment of the Maternal Protection Act, various issues have surfaced, as shown in **Table 2**. The most urgent subject we face currently is Item 13, the issue of "appointment and management rights of designated physicians under the Maternal Protection Act."

### Appointment and Management Rights of Designated Physicians under the Maternal Protection Act

The Maternal Protection Act is the only law that entrusts the execution of administrative right (as in the appointment right of designated physicians) to prefectural medical associations that are civil groups. Under Article 14, the appointment right of the designated physicians under the Maternal Protection Act was originally designated to "a medical association established to manage a prefecture within its boundary that is

**Table 2 Issues with the Maternal Protection Act**

- 1) Reflects eugenic ideas
- 2) Dissent due to religious reasons
- 3) The applicability (of gestational limit of fetal viability) changes
- 4) How to approach drug-induced abortion (PDF2  $\alpha$ , emergency birth control)
- 5) Separation between applicability and reality (for economic reasons)
- 6) Abortion after divorce
- 7) Induced abortion in teens
- 8) The risk of medical accidents and induced abortion (anesthetization, hemorrhage, uterine perforation, misidentification, handling of the expelled materials, Rh sensitization)
- 9) Appointing criteria of designated physicians and the facilities
- 10) The need to obtain consent from the spouse for abortion
- 11) How to approach *the fetus clause* when applicable
- 12) How to approach the reduction procedure in multifetal pregnancy
- 13) Appointment and management rights of designated physicians under the Maternal Protection Act

an incorporated association.” But as the reform of the public interest corporation system progresses in Japan, it has been revised to “a medical association established to manage a prefecture within its boundary that is a public interest incorporated association” (promulgated on Jun 2, 2006; enforced on Dec 1, 2008). And yet, the survey conducted by Japan Medical Association (JMA) (Oct 2009) revealed that many prefectural medical associations would not seek to be public interest incorporated associations. According to this survey, 13 plan to become public interest incorporated associations, 6 plan to become general incorporated associations first and then switch to public interest incorporated associations, 6 plan to become general incorporated associations, and 22 are still under consideration.

If only the prefectural medical associations that are public interest incorporated are to have the appointment rights under the Maternal Protection Act and those that are general incorporated are to lose their appointment rights, a serious problem will arise with the operation of this Act. It has been over 60 years since the Maternal Protection Act was first enacted as the Eugenic Protection Act, and during these years, the execution of the appointment right by prefectural medical associations and the operational management by prefectural branches of JAOG have been conducted smoothly. The execution of the appointment right by a prefectural medical association itself is an execution of administrative right by a civil organization, but I am very certain that it was properly done. Designated physicians are also considered to have

followed the ethics and have performed operations safely. A system that has been operated properly must not be dismantled by the reform of the public interest corporation system, which is of no relation.

There are two fields of medicine that require a “legal qualification” besides a “medical license” based on the Medical Practitioners Act—namely, medical procedures based on the Maternal Protection Act and the Act on Mental Health and Welfare for the Mentally Disabled. Both fields of medicine are given special consideration, as the former deals with “medicine that involves life” while the latter deals with “medicine that involve human rights.” Accordingly, only the limited “designated physicians” are allowed to practice such fields of medicine.

Thus, when someone applies for a new appointment or renewal as a designed physician, his/her professional knowledge, skills, and ethics are examined. Induced abortion not only closely relates to maternal and child healthcare, it also concerns issues such as population problems and social morality. Therefore, physicians performing the procedure must be highly discerning and ethical, constantly devoting themselves to improving their practice. JMA and Ministry of Health, Labour and Welfare of Japan hold “Workshop for Instructors of Family Planning and Maternal Protection Act” every year, to which representatives from the JAOG branches attend. Also, each JAOG branch hosts “Workshop for Maternal Protection Act Designated Physicians,” striving to offer more training. JMA has been taking the initiative in providing workshops like this

**Table 3 The legal applicability of induced abortion**

<p><b>To protect and maintain maternal health, as observed in Japan</b></p> <p>(1) Medical applicability (maternal protection)</p> <p>(2) Ethical applicability (rape, etc.)</p> <p>(3) Medical/social applicability (prolificacy, etc.)</p> <p>(4) Social applicability (poverty, difficulty of raising a child due to economic reasons)</p> <p>(5) Fetal applicability (increased physical and/or economic burden after birth)</p> <p>Example: The mother contacts rubella during the first trimester, and there is a high chance of giving birth to a fetus with congenital rubella syndrome.</p> <p><b>To control the period during which abortion is allowed, as observed in the USA and other countries</b></p> <p>(1) USA: Normally within 12 weeks of pregnancy. For pregnancy due to assault, abortion is allowed for higher gestational age. Partial birth abortion (fetal lamination, etc.) is prohibited.</p> <p>(2) France: Within 10 weeks of pregnancy</p> <p>(3) Italy: Within 90 days of pregnancy</p>
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one, too.

For a new appointment or renewal of a designated physician, peer reviews by other physicians who know his/her personality and capability is more appropriate than an administrative examination. The appointment right of designated physicians for the Maternal Protection Act should not be changed in its nature from the current method.

### Other Problems

As we face the revision of the Maternal Protection Act, there are issues that have been considered questionable (**Table 2**)—for example, the need of consent for abortion (from the spouse) (**Table 2**, Item 10), the approach toward *the fetus clause* to be applied (Item 11), and the approach toward the reduction procedure in multifetal pregnancy (Item 12).

Article 14 of the Maternal Protection Act states, “induced abortion can be performed, provided that consent from both the woman and her spouse is provided.” Some hope that “the consent from the spouse” will be omitted so that “the consent from the woman herself who receives induced abortion” will satisfy the requirement as a principle. Their reasons include: 1) The sexual behavior of females has diversified and became more active in recent years, and obtaining consent from the spouse or partner can be difficult in many cases, 2) Some cases led to lawsuits (for example, a female lost contact with the male partner and had an abortion, but the male sued the female and her father), 3) Based on the viewpoint of reproductive health and rights, females

have “the right to freely and responsively decide the number of children they wish to bear and the interval between pregnancies,” and 4) Many countries such as the USA do not require consent from the spouse or partner.

However, revising the Maternal Protection Act will demand considerable time, and is expected to meet difficulties. In Japan, “the equality of the sexes” is stipulated under the Constitution (Articles 14 and 24) and Civil Code (Article 2), and thus situations are different from those countries where males and females each have own right (i.e., the right of privacy) such as the USA. Parental authority is highly valued in Japan, and is the most common target of dispute in divorce. Based on the interpretation that the parental rights of a fetus should be the same as a married couple, it is highly likely that the consent from the spouse or partner will be deemed necessary for induced abortion.

As for the issue of whether to add *the fetus clause* as applicable cases of induced abortion, unlike in European countries and the USA, induced abortion in Japan is a medical procedure allowed only as the exclusion of illegal abortion in order to protect maternal health (**Table 3**). Adding *the fetus clause* will involve revision of the Penal Code, and thus it will not be easily achieved.

In addition, there is the issue of how to approach the reduction procedure in multifetal pregnancy within the Maternal Protection Act. Article 2 Item 2 of the Maternal Protection Act states, “In this Act, induced abortion shall mean the expulsion of the fetus and its appendages out of the mother’s body during the period when

the fetus cannot maintain its life outside the mother's body." As the reduction procedure does not involve "the expulsion of the fetus and its appendages out of the mother's body," it therefore does not meet the definition of induced abortion. The reduction procedure is performed as an emergency medical act to protect maternal health. Since the reduction procedure involves issues of legal interpretation, its radical revision

is not a simple matter—and therefore, it is probably for the best to maintain the way it operates now.

It is my hope that the Maternal Protection Act be operated properly and smoothly, and that its revision be instrumental in promoting healthy maternal and child healthcare as it was intended to.