Feticide and late termination of pregnancy: five levels of ethical conflict

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ABSTRACT
Technological advances in medicine have changed the landscape of fetal medicine considerably. Growing knowledge in fetal physiology, ultrasound, antenatal screening and an emphasis on preventive medicine promotes the detection of a wide range of abnormalities leaving both parents and obstetricians with difficult choices at various stages during pregnancy.

Early terminations are ethically controversial. However, late terminations (>20 weeks gestation) and feticide (including post-viable fetuses) have advanced the debate on the ethics of abortion. Poignant ethical questions surround the status of the fetus as opposed to that of the newborn. While most regulations regard severe fetal abnormalities as being incompatible with life and having the potential to cause severe pain and suffering after birth, slippery-slope arguments are raised when feticide is performed for abnormalities like cleft lip and palate.

Respecting the autonomy of the mother who may request a termination late in her pregnancy raises enormous ethical conflict for the treating obstetrician who must balance this request against the principle of non-malfeasance (doing no harm) inherent in killing a viable fetus. There is a clear moral distinction between actively killing an abnormal viable fetus and allowing an abnormal newborn to die after birth. This distinction may be lacking in policy-making in countries with a permissive feticide policy and a restrictive neonatal policy in respect of non-treatment. Furthermore, where feticide is concerned, do obstetricians have a right of conscientious objection globally?

At a more complex level, destruction of a viable fetus with significant abnormalities raises concerns of eugenics. Is feticide and late termination of pregnancy discriminatory towards people with disabilities and a veiled attempt to create a genetically pure population?

This paper explores the ethical conflict and legal inconsistency in feticide and late termination of pregnancy at a global level and argues for a universal policy based on fetal status and acknowledgment of the moral distinction between killing and letting die.

Key words: Ethics; Feticide; Late termination of pregnancy

Introduction

Technological advances in medical science have both enhanced and expanded antenatal health care. In fetal medicine, three- and four dimensional ultrasound, magnetic resonance imaging (MRI), intrauterine fetal therapy and genetic testing have led to the detection of fetal abnormalities at all gestational ages including the period of viability and beyond.[1,2] While the preference is for abnormalities to be detected early, there are several instances in which abnormalities may only be detected late in pregnancy. These include late bookings at antenatal clinics especially in resource depleted settings, missed early abnormalities and those abnormalities that are only detectable as pregnancy advances. While such scientific progress is exciting and innovative it is inescapably accompanied by ethical and legal complexity. New moral dilemmas have emerged and have served to advance the ethical debate on termination of pregnancy (TOP) and feticide.

Abnormal ultrasonographic findings after 24 weeks gestation create ethical dilemmas for parents and the treating obstetrician alike. Upon diagnosis of a fetal anomaly, parents may decide to continue with the pregnancy or to request fetal therapy if indicated.[2] On the other hand, they may decide to consider the option of late TOP (after 20 weeks gestation) or feticide. In the case of multiple pregnancy, selective reduction[3] is also an option.

Procedurally, feticide and late TOP differ; feticide involves

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methods aimed at directly and deliberately killing the fetus so that the mother delivers a dead baby[4] while a late TOP involves methods to prematurely end the pregnancy. The result might include the delivery of a viable or live baby which may then be left to die. Conceptually, the outcome is the same - the premature and artificial death of a fetus.

Moral Status of the Fetus versus the Newborn

The ethical debate surrounding late TOP and feticide stems from an understanding of the moral status of the fetus. Closely linked to this is the moral status of the newborn.[5] As such the first level of ethical complexity facing both obstetrician and patient are the policies surrounding these two moral entities. The moral status of the fetus is related to theories alluding to a definition of the beginning of life. These definitions range from life existing at conception to life beginning at birth. Such definitions vary across cultures, religions, philosophies as well as geographically. Biologically, the fetus is accorded medical, ethical and legal significance at viability – the point in the gestational cycle at which independent extra-uterine survival is possible. Viability is currently defined at 24 weeks of gestation in most parts of the world.[5,6] Before 24 weeks the fetus is generally not accorded moral status. The mother may choose to confer moral status prior to viability. Globally, most countries confer moral status upon the fetus after 24 weeks. In the medical environment the ''fetus as patient''[7] becomes relevant after 24 weeks except in those countries, like Israel, where moral status is conferred only after birth.[6] Legal status of the fetus varies globally ranging from post viability in the United States to post delivery in Israel and South Africa.[8]

The moral status of the newborn, on the other hand, is very clearly established. There is universal consensus that newborns have both moral and legal status. However, policies on how absolute such status is differ globally.[6] For example, where moral and legal status of the newborn is regarded as absolute (as is the case in Israel) parents lack the choice of withholding or withdrawing treatment after birth of an abnormal child. Such countries tend to have more lenient policies on late TOP and feticide after viability. Parents must therefore make their decisions early. As a result, Israel has one of the highest TOP and feticide rates in the world.[5] The United States, on the other hand, has a strict policy on TOP after viability but allows parents to decide to withhold or withdraw treatment of neonates in the event of severe congenital abnormality. In the case of less severe abnormalities however, parents may not withdraw treatment based on quality of life arguments.[5,6] Neonatal moral status therefore exerts a significant influence on policy making around late TOPs and feticide.

Maternal – Fetal Conflict

The second level of ethical conflict that arises in feticide and late TOP involves the debate over maternal and fetal interests. Here again the moral status of the fetus applies. Prior to viability, maternal interests take precedence. Post viability, fetal interests predominate in most countries except where the life of the mother is threatened or where the fetus has a serious, severe life-threatening abnormality. The burden carried by a mother who knows that her fetus is seriously malformed or will have a short post-delivery survival accompanied by suffering and/or prolonged hospitalization or repeated surgery is significant.[9] Her autonomous choice may thus be to terminate the pregnancy on the basis of compassion for her child, self determination or self-interest. The obstetrician faces the dilemma of respecting the autonomy of the mother and harming or killing the fetus. The notion of the ability of the fetus to feel pain especially from 23-26 weeks exacerbates the concept of harm in feticide.[10]

Degree of abnormality and Slippery Slopes

Pregnant women may request a late TOP or feticide for a spectrum of different reasons.[7,11] Serious severe life-threatening congenital abnormality early in pregnancy does not create ethical conflict. In general the reproductive choice of women to terminate pregnancy or request feticide in instances of severe life threatening congenital abnormality must be respected. However when the request arises due to a potential disability that is not life-threatening such as Down's or cleft lip/palate, this becomes more ethically questionable. At the extreme end of the spectrum, late TOP requests may also arise in the absence of fetal abnormality – where a pregnancy is inconvenient in economic terms or where career choices of the mother are prioritised. Slippery-slope arguments will therefore apply where indications for feticide or late TOP may include less serious disability or even a normal fetus. The ethical conflict at this third level relates to the degree of abnormality that can be considered sufficient to warrant a late termination or feticide.

Conscientious objection to performing TOP/Feticide

The obstetrician who must respond to a request for feticide or late TOP faces a fourth level of ethical conflict. S/he must consider the indication, the autonomy of the mother as well as his/her own value system. A disjunction exists between the willingness of obstetricians to accept TOP and feticide and their corresponding willingness to actually perform these procedures. Savulescu argues that doctors may claim a right to conscientious objection and refuse to conduct feticide or late TOP provided that other obstetricians are available to perform these procedures. In more remote areas where fewer obstetricians are available, he argues that it is unethical for obstetricians to refuse to conduct a late TOP or feticide.[11]

Eugenics and discrimination against "abnormality"

Finally, late TOP and feticide may be regarded as a form of eugenics especially when the indications include abnormalities that are not life-threatening. Passive eugenics is intended to remove any degree of abnormality from society and is inherently discriminatory towards the disabled.[7] An ultimate aim of modern medical science is the creation of a genetically pure human race. Severe criticism was levelled against Hitler, his dream of a eugenic society and the ''Law for the prevention of genetically diseased descendants'' implemented in 1933.[12] How far are we from creating a similar ''utopia'', based on perfectionistic and hedonistic utilitarianism?[7]

Conclusion

The ethical controversies surrounding feticide and late TOP are globally concerning as disparate policies exist between and within nations creating ethical and practical difficulties. This disparity may be accounted for by varying definitions of

fetal status, cultural norms and distributive justice. However, even in countries with similar cultural values, there is wide discrepancy in policies relating to feticide. Whether a fetus has a right to life often depends on its gestation, the severity of its abnormalities, the country's policy on fetal and neonatal moral status and even the centre in which its mother is receiving antenatal care.[7]

Only 20% of all pregnancies end in abortion. An even smaller proportion results in a late termination or feticide. However, when the request is made, it is fraught with ethical concern. It is hence imperative that all obstetricians and obstetric units – in public and private practices, have evidence-based protocols and policies in place. Such policies must consider the important concepts of fetal and neonatal moral status. Ultimately, a universal policy on fetal and neonatal moral status will ensure a universal right to life or death for all fetuses, irrespective of where in the world they exist.

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