

The ethical dilemma of termination of pregnancy for minor fetal deformity

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One of the authors, during early clinical training, encountered a 26-year-old pregnant woman admitted to the labour ward with gross polyhydramnios in early labour. She experienced rupture of membranes, then presented with antepartum haemorrhage and fetal distress. An emergency lower segment caesarean section was arranged. Unfortunately, her baby had trisomy 18. She experienced massive haemorrhage, partly due to placental abruption and polyhydramnios, resulting in disseminated intravascular coagulation. She received more than 20 units of blood transfusion and required a total hysterectomy.

In the 1990s, ultrasound machines were not widely available in most obstetric units. Frequently, we encountered mothers delivering babies with lethal conditions such as anencephaly, renal agenesis, lethal skeletal dysplasia, Edwards syndrome, or Patau syndrome in the delivery suite. This was a very distressing experience for the mothers, their partners, family members, and the attending obstetricians. When morphology scans were introduced, it became a rewarding experience for parents and clinicians because these lethal conditions could be detected earlier. Early detection allowed termination of pregnancy, reduced maternal morbidity, and prevented distressing experiences for both parents and attending staff.

As ultrasound resolution improved, more treatable but serious conditions such as diaphragmatic hernia, congenital heart disease, gastroschisis, exomphalos, and fetal bowel obstruction were detected. In large countries (eg, the United States, the United Kingdom, and Australia), prenatal detection of these congenital malformations allowed in utero transfer to tertiary centres with qualified neonatologists and paediatric surgeons, who could provide appropriate and timely neonatal resuscitation. This substantially reduced neonatal morbidity and, in some cases, neonatal mortality.

On one hand, prenatal diagnosis enables early detection and in utero medical or surgical intervention. The clinical outcomes of Rhesus isoimmunisation and twin-to-twin transfusion syndrome have greatly improved with in utero blood

transfusion and laser ablation of placental vessels. Other conditions, such as congenital diaphragmatic hernia, aortic stenosis, and spina bifida, have also shown improved outcomes with prenatal treatment. In these situations, physicians look through the pregnant woman to the fetus and regard the fetus as a distinct patient.¹ On the other hand, overly aggressive treatment may result in long-term morbidity in the surviving child.²

As pregnant mothers and families have become more receptive to termination of pregnancy, the detection of babies with clinically significant disabilities allows parents the option to discontinue the pregnancy. Termination is often offered to parents expecting babies with Down syndrome or spina bifida, and screening for these conditions has become routine in clinical practice.

With higher-resolution ultrasound machines, specialists can now detect minor fetal deformities such as microtia, syndactyly, oligodactyly, polydactyly, and other small defects, including minor ventricular septal or muscular septal defects. In recent years of private practice, there has been an increasing number of couples concerned about such minor deformities, likely due to greater awareness through social media and internet blogs. There is also a growing willingness to terminate pregnancies involving minor deformities, including cleft lip, microtia, oligodactyly, and minor correctable heart lesions.³⁻⁶

Sometimes, prenatal detection of conditions such as transposition of the great arteries or an aortopulmonary window can improve clinical outcomes. It is, however, frequently disappointing to find that parents decide to terminate these pregnancies because they cannot accept the presence of a large mediastinal scar or the small risk of serious complications associated with major cardiac surgery.

As medical professionals, we have an obligation to counsel such couples before termination of pregnancy. Many of these abortions involve minor deformities and occur close to the time of viability. A number of couples choose termination because they feel they can only accept a 'perfect child'. For these parents, in their view, the morphology scan must be

‘perfectly normal.’ When minor or major deformities are detected, the perceived solution is to terminate the ‘imperfect child.’ Termination of pregnancy is legal under two circumstances: (1) if continuation of the pregnancy would involve greater risk to the life, physical, or mental health of the pregnant woman than termination; and (2) if the child to be born would be severely handicapped due to physical or mental abnormality.⁷ Many terminations for minor fetal anomalies are justified on the grounds of maternal mental health. To reduce potential misuse, psychological assessment should be considered.

Most gynaecologists agree to perform termination of pregnancy out of respect for maternal autonomy. Many obstetricians also support this option, given that it is less likely to result in subsequent medicolegal issues. Some fetuses with minor defects may have underlying genetic disorders that cannot be detected prenatally. Various reasons have been cited by couples who choose termination for minor fetal defects, including negative perceptions of disability, cultural biases against disabled individuals, social stigmatisation, intense societal competition, and high parental expectations.^{3,8-10} Gynaecologists treating these women should be reminded that false-positive findings can occur, ranging from 1% to 9% according to different reports.^{11,12} The false-positive rate in prenatal ultrasound is not insignificant; such misdiagnoses cause psychological distress for parents and lead to over-medicalisation of both the pregnancy and the child.

With advances in cosmetic and reconstructive surgery, many minor deformities can now be corrected to achieve near-normal and aesthetically acceptable results.¹³⁻²⁰ Thus, before deciding on termination of pregnancy, couples should be counselled by appropriate specialists, including ENT (ear, nose, and throat) and plastic surgeons, as well as other relevant subspecialists. These experts can provide up-to-date information regarding surgical outcomes, which may help reduce anxiety and prevent unnecessary terminations based solely on external appearance. Furthermore, with advances in molecular genetics, many genetic syndromes can now be confidently excluded, thereby alleviating anxiety for both parents and attending obstetricians.²¹⁻²⁴

In Hong Kong, legal abortion is permitted only before 24 weeks of gestation.⁷ In many countries, including the United Kingdom and France, termination after 24 weeks is allowed when two doctors agree that there is a serious threat to the pregnant person’s life or in cases of severe fetal disability.²⁵ Similar practices could be considered in Hong Kong to allow more time for investigations and for couples to reflect carefully before making a decision about abortion. To prevent misuse, however, clearly defined indications should be established.

Practitioners who care for pregnant women

face dilemmas when patients exercise autonomy in ways that may result in adverse or unfavourable outcomes for their babies or fetuses. Many ethicists characterise such situations as maternal–fetal conflicts. In conflict-based models, maternal rights are viewed as conflicting with fetal rights, or moral obligations owed to pregnant women are considered in opposition to those owed to their fetuses. Invoking the Hippocratic dictum “Do good, or at least do no harm” as the physician’s primary moral obligation, it can be argued that beneficence toward the patient always overrides respect for autonomy. Thus, prioritising beneficence toward the fetus may, in effect, override not only respect for the pregnant woman’s autonomy but also beneficence toward her.

This commentary aims to stimulate further debate among medical professionals, legal practitioners, and lawmakers. Should parents have full autonomy to terminate a pregnancy for all minor fetal defects? Do gynaecologists have the right to refuse to perform such procedures? How should the medical profession responsibly address this issue? Should legislation permit late termination of pregnancy beyond 24 weeks?

Author contributions

Both authors drafted the manuscript, approved the final version for publication, and takes responsibility for its originality, accuracy and integrity. Both authors had full access to the data, contributed to the study, approved the final version for publication, and take responsibility for its accuracy and integrity.

Conflicts of interest

Both authors have disclosed no conflicts of interest.

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