Late termination of pregnancy: Maternal counselling and fetal rights

To the Editor: Govender and Moodley[1] are to be commended for the careful way in which their multidisciplinary team has been assembled and in which it functions in the assessment of fetuses with abnormalities. But Doctors for Life considers that their article does require comment.

They write: 'Contrary to the belief that religion plays a major role in end-of-life decision for the unborn baby, we found that the decision-making processes was not influenced by maternal age, parity, social status or gestational age (GA) at diagnosis of fetal anomaly.' Apart from this sentence being a *non sequitur* about religion, they then went on to report that women of greater age and parity, and women at a more advanced gestational age, were less likely to agree to feticide. That is an important comment, because it suggests that these women's experience of life gives them a greater understanding of the dynamics of maternal-infant bonding, which makes them resist the idea of feticide because they have a greater sense of reverence for the personhood of their babies. When a baby has a lethal abnormality which is not compatible with extra-uterine life, many women who refuse feticide or abortion describe the personal growth, and the help

in their grief, which came from the opportunity to hold and care for their babies after birth. The duration of life enjoyed by the baby was often not of great consequence. Feticide can easily interfere with this process of grieving.

This highlights an important issue in the management of women accepting feticide. Human grief is a complex process, and women who have stillbirths experience grief and guilt feelings which are as sharp and as deep as those who lose a neonate. Feticide is bound to deepen such grief and guilt feelings because of the woman's own part in deciding to kill the baby. Women who decide on feticide are therefore a group who are especially vulnerable psychologically and spiritually. This is a probable factor in the poor follow-up achieved in this study. In addition, the need to send the women back to their often poorly staffed base hospitals breaks the supportive bond that they develop with those who counselled them in their crisis. The article does not state that base hospital medical and midwifery staff members were warned of the women's need for special emotional care. It is surely important that the grief experiences of these women should be further investigated, and that this structure be re-examined.

The list of indications for feticide in this study includes a number of conditions which are not lethal: twins, skeletal abnormalities, cardiac and renal anomalies, hydrocephalus, spinal lesions, trisomy 21 and Turner's syndrome. Additional information is really needed if readers are not to conclude that utilitarian, even eugenic thinking is being applied when the offer of feticide is made to such mothers. The babies themselves surely have value and their lives have meaning, even if they are handicapped.

The history of the last century holds serious warnings that eugenic thinking can too easily be extended to include many other vulnerable groups, creating chaos in nations. And it has sometimes begun with killing handicapped newborn babies. Late-gestation feticide based on our legislative myth that the fetus has no rights can become just an elegant substitute for infanticide.

J V Larsen
Doctors for Life
jon.larsen@iuncapped.co.za

1. Govender L, Moodley J. Late termination of pregnancy by intracardiac potassium chloride injection: 5 years' experience at a tertiary referral centre. S Afr Med J 2013;103(1):47-51. [http://dx.doi.org/10.7196/SAMJ.6006]

Govender and Moodley respond: Doctors for Life are to be thanked for their comments on and interest in our paper.[1] While the main emphasis of this paper was a retrospective audit of the procedural technique of intracardiac potassium chloride (KCl) for late termination of pregnancy (LTOP) and the outcomes thereof, it is acknowledged that the patients' rights in the decision process and beyond are equally important and were procedurally respected at this unit.

Although it was mentioned in the Abstract and Results sections that religion, in addition to the other factors mentioned, did not influence the decision-making process among the women in this study, it was an omission not to state this in the Discussion section.

It was observed from this audit that 20% of the women with severe fetal anomalies were >35 years old with proportionally lower acceptance rate. While the opinions and comments expressed by Doctors for Life on the moral aspects of feticide, especially with regard to these older women, are acknowledged – these are beyond the scope of this paper.

The decision to offer women the option of LTOP (where the anomaly was considered severe enough to result in severe mental and/or physical handicap should the child survive, or to be lethal in nature) was first agreed upon by the multidisciplinary team prior to counselling the women. Severe and lethal anomalies may affect any organ system(s) such as the heart, kidneys, lungs and skeleton. Such anomalies can also occur in multiple pregnancies where one or more fetuses may be affected with such anomalies. All counselling was non-directive and non-judgmental, ensuring that the women's and their family's wishes and cultures were respected and their decisions supported. Furthermore, counselling was done in offices away from the rooms that housed the scanning machines.

Inkosi Albert Luthuli Central Hospital is a tertiary/quaternary referral hospital. Many patients come from distant geographical areas. It is the hospital's protocol that all low-risk patients are referred back to their base hospital for delivery, with a referral letter containing relevant information on management and delivery, ongoing counselling and postnatal follow-up – including a date for further follow-up with our genetic counsellor, and the psychologist and social worker as required. Ongoing support and counselling are provided to the patient and her family. Most base hospitals have trained counsellors. It is standard practice to offer all women the opportunity to see and hold their baby after delivery.

Delivery at the base hospital saves on costs and arrangements for transport of the dead baby back to the woman's hometown. Most women, in fact, preferred to be closer to their homes for their delivery.

Patients may be lost to follow-up for a variety of reasons, not peculiar to our study. Many were from distant locations without contactable addresses and telephone numbers, posing a challenge to follow-up.

From the authors' perspectives, after the necessary and appropriate counselling, every woman should be given the opportunity to make informed choices in respect of her unborn baby. Clearly it was never the aim of the authors to practise eugenics. Rather we sought to respect and support whatever decision a woman made, irrespective of the nature and severity of the anomaly. We continue to do so.

The fetus has no rights from a legal perspective. However, the moral and ethical debate is likely to continue.

L Govender
Lower Umfolozi District War Memorial Hospital and University of KwaZulu-Natal, Durban, South Africa

J Moodley
University of KwaZulu-Natal, Durban, South Africa
tombe@ukzn.ac.za

1. Govender L, Moodley J. Late termination of pregnancy by intracardiac potassium chloride injection: 5 years' experience at a tertiary referral centre. S Afr Med J 2013;103(1):47-51. [http://dx.doi.org/10.7196/SAMJ.6006]

S Afr Med J 2013;103(5):274-275. DOI:10.7196/SAMJ.6764