Ethical and medico-legal aspects of the therapeutic abortion - our experience

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Abstract: Objective. Our study aims to analyze the indications for therapeutic abortion and to discuss the legal implications of this procedure in Romania.

Methods. We performed a retrospective cohort study of singleton and as well as twin pregnancies terminated for therapeutic reasons between 2014 and 2016 in "Bucur" Maternity, Bucharest. The patients that were admitted in our clinic were cared by obstetrics-gynecology specialists, and interdisciplinary consults were requested if needed. We conducted blood tests, fetal morphology scans, amniocentesis as well as a complete survey of the patients' medical history, and the diagnosis was made according to the findings by a team of OG experts. The patients were given full access to information and guidance according to ACOG guidelines. The decision to terminate the pregnancy was made after undergoing prenatal and psychological counselling and after the patient was informed about the risks and complications of the procedure.

Results. A total of therapeutic abortions were conducted in our clinic from 2014-2016. In 65% of cases the causes were fetal, in 20% were maternal and in 15% maternal and fetal causes were reported. The mean maternal age vas 31.65 years, for maternal indications the means was 36.25 years and for fetal indications-plurimalformative syndrome diagnosed fetuses 27.57 years of age. 80% of the women were multiparous, with 55% non-smokers. The psychyatric maternal pathology dominated the maternal indications (4/7), and regarding the fetus related indications 7/13 were diagnosed with plurimalformative syndrome, 3 associated with T21 diagnosis. Regarding the procedure 35% were uterine curettages, 50% induced oxytocin births, there was one caesarean operation and one total histerectomy.

Conclusions. The most frequent reasons for therapeutic abortion were fetal anomalies. Considering the legal, ethical and medical implications the decision of pregnancy termination should follow only an accurate diagnosis, specialised team counseling and thoroughly informed couple. Legislation must differentiate therapeutic abortion from the challenge of premature delivery, therapeutic abortion not being ‘in the fetal interest’ while premature elective delivery may be maternal but also fetal.

Key Words: therapeutic abortion, legal norms, fetal anomalies.

INTRODUCTION

Abortion is defined as the removal of a fetus or embryo from the uterus prior to the stage of viability [1]. According to American College of Obstetricians and Gynecologist (ACOG) "Induced abortion is a essential component of women's healthcare” [2]. In the statement entitled Abortion Policy is emphasized that "Like all patients, women obtaining abortion are entitled to privacy, dignity, respect and support” [2].

According to the Romanian Penal/Criminal Code abortion is a permitted medical intervention in Romania given certain circumstances. As the new Romanian Penal Code states there are several obligatory conditions: it has to be completed only in medical institutions or authorized medical practices; the person which is designated to conduct the
procedure has to be a obstetric-gynecologic specialist with a valid license to practice;
the pregnancy has to be 14 weeks or less for the patients who demand an abortion regardless of medical conditions;
the procedure is also permitted up to 24 weeks of pregnancy an beyond for therapeutic reasons i.e if the health of the mother is endangered or if the fetus is diagnosed with severe abnormalities that are not compatible with life – therapeutic abortion, but only if the above mentioned conditions are present;
the pregnant woman must to give a written consent that she agrees with the abortion procedure and that she has been informed of all the risks an complications that can happen;
abortion can not be done if the woman does not want it or is against her will [3].

Any medical procedure meant to cause an abortion disregarding the above mentioned conditions is penalized by the Criminal/Penal code and the penalties are imprisonment and forbidding certain rights. In conclusion, if a doctor performs an illegal abortion, by not respecting the legal conditions in their entirety, may lose his license to practice and risks imprisonment.
Therapeutic abortion is the intentional termination of a pregnancy before the fetus can live independently and is justified by a maternal or fetal condition. Our study focuses on the fetal or maternal reasons which provides the background for abortion in consideration of ethical and medico-legal issues. The main concern about this background is raised by the ambiguous of the legal provisions. Ambiguity of legal stipulations does not provide a clear framework of what the therapeutic reasons are and a protocol to follow in such cases.

MATERIALS AND METHODS

This retrospective cohort study was conducted between January 2014 and January 2016, in three medical units: the Clinical Emergency Hospital “Saint John” - “Bucur” Maternity, “Saint Pantelimon” Clinical Emergency Hospital and “Elias” Hospital in Bucharest. Our cohort was composed of pregnancies admitted in our departments that underwent blood tests, fetal morphology scans, amniocentesis as well as a complete survey of the patients’ medical history, and the diagnosis was made according to the findings by a team of OG experts.

A database was filled with information regarding the patients’ pregnancy data and history, and only patients with complete data were included in the study. The gestational age was determined using the first day of the menstrual period, if the patient had regular periods and if the due date had been consistent throughout the pregnancy; if not, the gestational age was calculated using serial ultrasound examinations.

Our study aims describe and analyze the various fetal and maternal indications for therapeutic abortion in our clinic, and to correlate the findings with the ethical and legal aspects of the matter in question.

The incidence of fetal versus maternal indications for therapeutic abortion in our study population was roughly estimated. Descriptive statistics were used to describe and compare the baseline characteristics of the two study populations. Student’s t test was used for continuous variables, $\chi^2$ for categorical variables, or Fisher exact test for rare categorical variables. All statistical analyses were performed in SPSS 16.0.

RESULTS

The main characteristics of therapeutic abortion (TOP) performed in the three units are summarised in the tables. Although there is no guideline or consensus in our country for such cases in all centers with fetal malformation the couples were counselled by an expert in maternal fetal medicine. 65% of the indications were fetal-only related, with only 20% maternal and 15% mixed. The main indication for each cause are illustrated in Table 1. The procedures used for abortion are illustrated in Table 2.

The mean gestational age for therapeutic abortion was 17.4 (11+6 to 23+6) weeks of gestation.

There was one termination request at 30 weeks of pregnancy for agenesy of corpus callosum but it was declined considering the advanced pregnancy age and uncertain newborn impairment.

In one case a twin pregnancy from IVF one fetus was diagnosed with trisomy 21 and the couple choose elective feticide. The pregnancy was referred to a center where she undergone selective fetal umbilical cord coagulation with uneventful outcome and term delivery of the normal fetus.

DISCUSSION

Therapeutic abortion for medical reasons can be done both in the first trimester of pregnancy and in the second trimester. As legislation allows, often pregnancy discontinuation in the first trimester is at the patient’s request, without resorting to medical reasons. However, there is a difference, as the patient may benefit from the free of charge interruption of pregnancy if there is a medical reason for it.

Abortion on demand becoming illegal after 14 weeks of amenorrhoea, in Romania, in the second trimester the medical discontinuation of the pregnancy is possible only for therapeutic reasons.

In the second trimester the decision to terminate the pregnancy raises many issues:- the risks implied by the abortion must be justified by a severe deficiency,
lethal fetal condition or other acceptable motivation in the circumstance of the vague legal provision.

Decision should be taken by the couple according to their conscience, believes and after an extensive counselling provided by a team of specialists according to the reason that is core of decision.

The fetal medicine specialist is the first to counsel the couple about the anomaly and to organise the frame for further discussion, therefore he or she must not be inductive and the position must be neutral in providing information and squeezing the prognosis of the fetus.

Couples should benefit from psychological support throughout the whole process from the diagnosis to the mourning stage after termination of pregnancy.

In case of severe malformation that were at the base of TOP decision it is of tremendous importance that the fetus necropsy is performed and the malformations confirmed.

The definition of therapeutic aim provided by the Penal Code in Romania is very large and also very permissive. Therapeutic aim’s definition raise many debates. The need for a coherent legal framework to facilitate decisions on termination of pregnancy motivated by congenital abnormalities (procedural and institutional) is justifying lex ferenda proposals. According to the fact that at present the interruption of pregnancy is subject to Art. 201 CP that does not make it clear whether the interruption of pregnancy is justified for reasons of congenital abnormalities, but merely establishes a non-punishment clause for abortion beyond 24 weeks.

Penal Code Art. 201 (6) “It is not a criminal offense to interrupt the course of pregnancy for therapeutic purposes by a specialist obstetrician-gynecologist up to the age of twenty-four weeks of pregnancy or to discontinue the course of pregnancy for therapeutic purposes in the interest of mother or fetus”.

We should discuss the ethical, moral, professional issues related to this phrase “for therapeutic purposes, in the interest of the mother or the fetus”.

Considering termination of pregnancy, let’s just say that the fetus’s death can not be a therapeutic act for him even with the extent that he would be severely affected and the concept of euthanasia is accepted.

Perhaps the legislator wanted to refer to the fetal interest after reaching the threshold of fetal viability, and when there are indeed conditions that can impose a premature birth.

In this regard, the provision stipulated in the French Health Code for the therapeutic abortion seems more coherent: “Voluntary interruption of pregnancy can be practiced whenever two doctors of a disciplinary team attest, after giving their advisory opinion or continuing the pregnancy in serious danger to the mother’s life, whether there is a very serious possibility that the fetus is born with a disease of special gravity, recognized as incurable at the time of diagnosis” [4].

It also has the advantage of recording the evolutionary nature of medical science and the need to judge the medical act in the context of the knowledge and

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Table 1. Abortion indications

<table>
<thead>
<tr>
<th>Abortion indication</th>
<th>No</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maternal</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal</td>
<td>12</td>
<td>18.46</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>5</td>
<td>7.69</td>
</tr>
<tr>
<td>Tumors</td>
<td>6</td>
<td>9.23</td>
</tr>
<tr>
<td>Others</td>
<td>2</td>
<td>3.07</td>
</tr>
<tr>
<td><strong>Fetal and maternal</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fetal</td>
<td>9</td>
<td>13.84</td>
</tr>
<tr>
<td>Plurimiformated fetus normal cariotype</td>
<td>5</td>
<td>7.69</td>
</tr>
<tr>
<td>Cranium/SNC anomalies (anencephaly, encephalocel, hydrocephaly, holoprosencephaly)</td>
<td>7</td>
<td>10.76</td>
</tr>
<tr>
<td>Facial anomalies</td>
<td>3</td>
<td>4.61</td>
</tr>
<tr>
<td>Pulmonary anomalies</td>
<td>2</td>
<td>3.07</td>
</tr>
<tr>
<td>Cardiac anomalies (Hyoplastic left hearth syndrome, TOF, ASVD)</td>
<td>11</td>
<td>16.92</td>
</tr>
<tr>
<td>Gastrointestinal anomalies (Absent stomach /esopahageal atresia)</td>
<td>2</td>
<td>3.07</td>
</tr>
<tr>
<td>Abdominal wall defects (gastrochizis, omphalocele Cantrell Pentalogy)</td>
<td>3</td>
<td>4.61</td>
</tr>
<tr>
<td>Fetal hydrops</td>
<td>1</td>
<td>1.53</td>
</tr>
<tr>
<td>Partial trophoblastic disease (embrionate mola)</td>
<td>1</td>
<td>1.53</td>
</tr>
<tr>
<td>Chromosomial anomalies (T21, T13, T18, 46 Jx)</td>
<td>8</td>
<td>12.30</td>
</tr>
<tr>
<td>Total</td>
<td>65</td>
<td>100</td>
</tr>
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</table>

Table 2. Procedures used for abortion

<table>
<thead>
<tr>
<th>Procedure type</th>
<th>No</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>NOS-unknown</td>
<td>1</td>
<td>1.53</td>
</tr>
<tr>
<td>Medication and D&amp;C (Topogyn, Mifegyn)</td>
<td>27</td>
<td>41.13</td>
</tr>
<tr>
<td>Oxytocin induced</td>
<td>33</td>
<td>50.16</td>
</tr>
<tr>
<td>Caesarean operation</td>
<td>3</td>
<td>4.61</td>
</tr>
<tr>
<td>Total Hysterectomy</td>
<td>1</td>
<td>1.53</td>
</tr>
<tr>
<td>Total</td>
<td>65</td>
<td>100</td>
</tr>
</tbody>
</table>
standards of that time.

Regarding TOP another question rise: which are the diseases recognised as incurable, and how we determine the degree of severity?

According to the literature and EUROCAT (European Surveillance of Congenital Anomalies) reports, the main lethal anomalies accepted for TOP are anencephaly, condition that results in severe mental retardation (Down syndrome or other trisomy), plurimalformative conditions but also conditions with uncertain prognosis.

Even this authors state “Although there is no indisputable definition of which anomalies are ‘severe’, 93.6% of the decisions to terminate the pregnancy were made by women and professionals in reaction to anomalies which clearly were lethal or would lead to substantial physical and/or mental disabilities” [4].

Therapeutic abortion for fetal indication can be framed in a global concern for preventing birth defects as the WHO (World Health Organisation) Resolution WHA 63.17 from May 2010 states: “The Sixty-third World Health Assembly, Having considered the report on birth defects... urges its members... to support Member States in developing national plans for implementation of effective interventions to prevent and manage birth defects within their national maternal, newborn and child health plan...” [5].

To recognize fetal anomalies detection and prenatal diagnosis determined a joint venture effort in the European Union to fund and develop EUROCAT whose aim is to carry out epidemiologic surveillance of congenital anomalies in Europe [6]. Besides reporting the prenatal fetal anomalies the members of Eurocat provides information about TOP rules when fetal anomalies are detected. As our study revealed in the majority of cases abortion for the fetal anomalies were associated poor outcome: fetal demise in utero (fetal hydrops), short survival expectation after birth (trisomies, polimarformated fetuses), severe neurological impairment and handicap of the newborn (SNC anomalies), perspective of many surgery procedures with poor outcome or only palliative in cardiac anomalies. In such cases we can consider that fetal interest or therapeutical reason for abortion is justified. There are also some borderline conditions when TOP is chosen despite certain poor outcome (ie. isolated facial cleft or isolated nonsyndromic omphalocel). Parental choice in those casese are more cultural and social than medical conditioned.

In fetal anomalies based abortions the role of prenatal diagnosis is the main determinant and medical counselling is the corner stone. Counselling should be provided by a team of physicians that include the fetal-medicine specialist, genetician, a pediatric specialist and an obstetrician. Therefore relying for abortion only on Penal Code general norms and foreseeing a more clear and structured regulation induce insecurity for both patients and medical providers. The actual context is prone to individual interpretation and abuse form both parts and litigation that could be avoided by a more secured and structured legal frame.

An important chapter is also the maternal indications and remain a disputed factor. Even if they represent only 15% taked alone, their implications and consequences are huge. Mothers tend to neglect their state of health or accept inadmissible high risks from the desire to have children.

CONCLUSIONS

In most cases, the interruption of the pregnancy was done for fetal reasons. Taking a decision to discontinue pregnancy should be made after the diagnosis has been established as accurately as possible. Legislation must differentiate therapeutic abortion from the challenge of premature delivery, therapeutic abortion not being “in the fetal interest” while premature elective delivery may be maternal but also fetal. A clear procedure should be established whereby patients should be informed as fully and understandable as possible of the diagnosis, possible evolution, procedures for discontinuing pregnancy and the risks involved.

Conflict of interest. The authors declare that there is no conflict of interest.

References

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