AAPLOG
PRACTICE GUIDELINE

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Ethical Considerations in Ending a Pre-viable Pregnancy for Maternal-Fetal Vital Conflict

Pregnancy is a natural, self-limiting state of a healthy mother and the embryonic or fetal human being in her womb, usually ending in the separation of the mother and fetus with a healthy mother and a healthy neonate. The goal of obstetrical training is to equip an obstetrician to recognize when this natural process is going awry and to determine when and if intervention is necessary to maintain the health of both mother and fetus.

When disorders arise after the gestational age at which the fetal human being can survive outside of the mother's uterus (currently around 22 weeks of gestation, varying by institution), then interventions that require separating the mother and the fetal human being are timed and situated so as to maximize the survival and health of both patients. Most of the disorders that require such separations occur after viability and account for the vast majority of such circumstances. The skill and professional medical judgment of the obstetrician are exercised on behalf of both patients.

Yet, rarely, there are conditions before the fetus is capable of surviving separation which require separating the mother and her unborn child in order to avoid the mother's death or serious, irreversible impairment of a major body system.[1] *This practice guideline will explore the medical and ethical considerations that comprise the risk-benefit analysis from the perspective of physicians who do not perform direct intentional embryocide/feticide or separate a mother from her pre-viable fetus without proportionate risk to the mother's life (or to avert proportional irreversible damage to a major body system of the mother which cannot be avoided in any other way). This guideline will also explain the ethical principles involved in maternal-fetal vital conflicts, which are clearly distinct from decisions to end the life of the fetal human being for reasons other than to save the life of the mother or to avert proportional irreversible damage to a major body system when doing so cannot be accomplished in any other way.*

AAPLOG Practice Guideline. This document was developed by 6 authors on the Research Committee. Practice Guidelines are evidence-based documents informing pro-life providers with high-quality, peer-reviewed literature.

Background

Defining the term "induced abortion"

Uniform, clear definitions surrounding the ending of a pregnancy are essential for informed consent discussions between women's health care professionals and their patients, as well as for policymakers. The natural history, procedures, and risks for women with a living embryo or fetus are clearly different, both psychologically and physically, from the natural history, procedures, and risks facing a woman with embryonic or fetal demise.

The Centers for Disease Control and Prevention (CDC) clearly defines induced abortion as an intervention that intends embryonic or fetal death:

> For the purpose of surveillance, a legal induced abortion is defined as 'an intervention performed by a licensed clinician (for instance, a physician, nurse-midwife, nurse practitioner, physician assistant) within the limits of state regulations, that is intended to terminate a suspected or known ongoing intrauterine pregnancy and that does not result in a live birth.' This definition excludes management of intrauterine fetal death, early pregnancy failure/loss, ectopic pregnancy, or retained products of conception.[2]

The American College of Obstetricians and Gynecologists' (ACOG) most recently changed definition is less delineated. As of this writing (July 2025), in response to the question "What is abortion?" ACOG states that "Induced abortion ends a pregnancy with medication or a medical procedure."[3] This statement is so all-encompassing that it would include Cesarean section, induction of labor, and treatment of ectopic pregnancy. There is no new scientific information that precipitated this change from previous ACOG statements and, in fact, this response by ACOG contradicts their own definition. A "mouse hover" over "induced abortion" reveals, "An intervention to end pregnancy so that it does not result in a live birth." ACOG's page "reVITALize: Gynecology Definitions" similarly defines induced abortion as *"An intervention to end a pregnancy so that it does not result in a live birth."*[4]

Less clear is the definition provided by the Society for Maternal Fetal Medicine (SMFM). SMFM points out the need for standardized language around abortion, yet in contrast to the clarity provided by the CDC and the clear but less delineated definition provided by ACOG, SMFM states the following:

> In any attempt to discuss the nuances of language and terminology, it is prudent to begin with a definition of terms. ACOG reVITALize, endorsed by many national organizations, defines induced abortion as "an intervention intended to terminate a pregnancy so that it does not result in a live birth." Although the authors will use this as a working definition, we consider it vital to note that some families choose to terminate their pregnancy through induction of labor without a feticidal agent. Such a

decision may be specifically made to allow the possibility of a live birth accompanied by comfort care. The definition of abortion should include this course of care.[5]

Although the discussion of "comfort care" is beyond the scope of this practice guideline, remarkably, SMFM recognizes that the purpose of some inductions without feticide is still the death of the neonate.

In the interest of unambiguous communication with medical professional colleagues and in public health data collection, and for the purpose of every patient's informed consent, the American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG) proposes a clear definition of the term "induced abortion."

This practice guideline defines "induced abortion as:

1. The use of any drug, device, surgery, or any procedure or intervention with the purpose of ensuring the death of the *living* human being in utero before, during, or in the process of separating the mother and her embryo or fetus.
2. Any pre-viable separation of the mother and the *living* embryo or fetus in utero without proportional danger of maternal death or permanent irreversible damage to one or more of her major body systems.

This practice guideline also defines the following circumstances as NOT an induced abortion:

1. The removal of an embryo or fetus who has died of natural causes and/or the removal of placental tissue or remaining parts of the embryo or fetus after an incomplete induced abortion is not an induced abortion.
2. The separation of a mother and embryo or viable or pre-viable fetus in cases of threat to the life of the mother, such as ectopic pregnancy, sepsis, and other critical maternal illness prior to viability, which cannot be managed in any other way, is not an induced abortion, since the intent of the separation is not the death of the embryo or fetus. This is consistent with the CDC's definition of induced abortion.[2]

Separating a mother and her fetus after viability may be required to save the mother's life or to avoid permanent damage to her bodily organs. In those circumstances, the separation should be done under conditions where both mother and baby can receive appropriate medical care to maximize the chances of saving their lives.

The remainder of this guideline will delineate the ethical decision-making surrounding necessary pre-viable separations.

Ethical decision-making frameworks used in situations of pre-viable maternal-fetal separation when necessary to save a mother's life

Judging whether an action should be taken requires applying a philosophical framework to assess the rightness or wrongness of the action. Two predominant philosophical ethical frameworks are utilitarian ethics and virtue ethics.[6-8] In a utilitarian ethic, there is no intrinsically right or wrong action. The rightness or wrongness of the action is judged based on the outcome and maximization of good. In a virtue ethics framework, there are actions that are intrinsically right or wrong, and performing an action that is wrong is unethical.

The Hippocratic Oath[9] is a virtue ethics document, as it assumes that there are certain actions that are intrinsically wrong for a physician to perform. Among those are abortion and euthanasia, since a Hippocratic physician is committed at all times to the life of his or her patient(s). This guideline assumes that it is intrinsically wrong for a physician to intentionally end the life of a patient. An obstetrician is ethically bound to respect the inherent dignity of the unborn human being, regardless of gestational age, wantedness, or any perceived congenital or genetic imperfections, and to treat that unborn human being as a patient.

AAPLOG recognizes that there are situations where continuing a pregnancy presents a risk of foreseeable death of the mother and her fetus and that separating the mother and her fetus will result in the inevitable death of her pre-viable fetus. These situations are agonizing for the physician, the mother, the entire family, and the rest of the patient care team. The consequences of both action and inaction carry moral implications for all involved. It is essential that the physician consider and implement all reasonable alternative management options that could potentially mitigate the severity of the situation before proposing or resorting to pre-viable separation.

The decision to end a pre-viable pregnancy to save the life of the mother or to avert serious, irreparable bodily harm to a major maternal body system should not be undertaken solely by the health care professional but should incorporate shared decision-making with the patient. There is a critically important role for complete informed consent, and the mother should be made aware of all management options, including the consequences of both separating the mother and her pre-viable embryo or fetus and not separating them, which could include her death as well as the death of her child. The informed consent discussion should also include describing the process for separation and the mother's possible desire to see or hold the child afterwards. Consideration may be given to activating the perinatal grief management team at the health center, regardless of the decision made, as there will be a need for grief processing with family and with the staff and physicians involved in the management of these traumatic cases.

In considering the decision to end a pregnancy prior to viability due to a threat to the mother's life or threat of serious irreparable injury to a major body system, there is a useful ethical framework for evaluating the moral status of a proposed action that can cause both good and bad effects. This framework, utilized by ethicists of many traditions over the last 12 centuries, is called the Principle of Double Effect.[10]

The Principle of Double Effect

There are four essential elements to the Principle of Double Effect:

1. The action itself must be morally good or morally neutral. The action itself cannot be intrinsically evil.
2. The one who performs the action must be performing the action in order to produce the good effect, not intending to produce the bad effect. If the actor could avoid the bad effect, then he or she would.
3. The good effect is not a result of the bad effect. The bad effect must not be the thing that produces the good result.
4. The good effect has to be proportionate to the bad effect, with no better alternative possible.

<u>Applying the Principle of Double Effect to the Action of Separating the Mother from the Placenta</u>

In situations where continuing a pre-viable pregnancy threatens the mother's life, it is often not the embryo or fetus per se which is causing the threat, but rather placental factors, for example: 1) the growth of the placenta outside of the uterus in the case of ectopic pregnancy, 2) factors elaborated from the placenta in the case of pre-eclampsia, 3) hemorrhage caused by placental separation in the case of abruption, 4) infection of the placenta and amniotic fluid in the case of chorioamnionitis, etc. Thus, the necessary action to save the mother's life is to treat the disease process directly, i.e., remove the placenta (or in some cases of ectopic pregnancy, to medically kill the cells of the placenta). This action must be taken regardless of whether the fetus is alive or dead at the time of removal.

Before the fetus can survive outside the womb, removal of the placenta will foreseeably result in fetal death. However, the death of the fetus is not the action intended, nor is it the action that saves the mother's life. Thus, in a pre-viable delivery, the action of removing the placenta without a direct attack on the embryo or fetus is the moral action that is subject to analysis under the Principle of Double Effect.

1. The action of separating the mother from the placenta is not in itself intrinsically evil, as illustrated by the fact that in vaginal deliveries and in Cesarean sections, a medical professional separates the mother and placenta, and this is a necessary and good part of the delivery process.
2. The medical professional who separates a mother from the

placenta in order to save the mother's life is performing that action to produce the good effect of saving the mother's life and avoiding the bad effect of the death of both the mother and her embryo or pre-viable fetus. The bad effect is that the separation of the mother and the placenta cannot be performed without resulting in the unavoidable death of her embryo or pre-viable fetus. But if the medical professional could perform the separation of the mother from her placenta and save the embryo or pre-viable fetus also, he or she would do so.

3. The good effect of saving the mother's life comes from separating her from the placenta in these situations, not from the death of her embryo or pre-viable fetus. The death of her embryo or fetus is not the action that saves her life. She has to be separated from the placenta regardless of whether the embryo or fetus is alive.
4. The good effect of at least saving the mother outweighs the bad effect of the death of her embryo or pre-viable fetus. If no separation takes place, both the mother and her embryo or pre-viable fetus will die. If the separation of the mother from the placenta takes place, then the good of saving at least the mother outweighs the inevitable death of her embryo or pre-viable fetus.

Examples: Applying the Principle of Double Effect in Scenarios of Mortal Risk to the Mother

To better understand how this principle can be applied in medical practice, it is useful to consider the following clinical scenarios:

1. Ectopic pregnancy: 27-year-old G2P1001 with a tubal ectopic pregnancy at 8 weeks of gestation with a positive fetal heart rate

   Q: What is the treatment that will save her life: separation of the mother from the placenta growing in her fallopian tube, or intentionally killing her embryo or fetus?

   A: Separating the mother from the growing placenta (or medically killing the placenta with methotrexate) is the act that saves her life, regardless of whether the embryo/fetus is alive at the time of separation. Intentional embryocide/feticide is not a life-saving treatment. The death of her child is unavoidable due to gestational age, but the death of her child is not the action that saves her life; rather, it is a tragic, unavoidable consequence. If we could save her child while also saving her, we would do so.

2. Pre-eclampsia: 25-year-old G1P0 at 20 weeks of gestation with HELLP Syndrome

Q: What is the treatment that will save her life: separation of the mother from her placenta, or intentionally killing her fetus?

A: In this scenario, separating the mother from the placenta is the act that saves her life, regardless of whether the fetus is alive at the time of separation, as pre-eclampsia is essentially a placental disease. Therefore, killing her fetus (intentional feticide) is not the life-saving treatment. The death of her pre-viable child at this gestational age is unavoidable, but the death of her child is not the action which saves her life, but rather a tragic, unavoidable consequence of the life-saving intervention. If they were far enough along in the pregnancy that we could save her child, we would do so.

3. <u>Chorioamnionitis: 18-year-old G3P2 at 17 weeks gestation, preterm pre-labor rupture of membranes (PPROM) with intraamniotic infection with or without sepsis</u>

   Q: What is the treatment that will save her life: separation of the mother from the infected placenta, or intentionally killing her fetus?

   A: Separating the mother from the placenta is an act of source control in the treatment of intraamniotic infection or sepsis. It is the separation of the mother from the placenta that saves her life, regardless of whether the fetus is alive at the time of separation. So, killing her fetus (intentional feticide) is not the life-saving treatment. The death of her child is not the action which saves her life, but rather a tragic, unavoidable consequence. If we could save her child, we would do so. This concept is well illustrated by the treatment of chorioamnionitis at or near term. The treatment is delivery, not intentional feticide, in this circumstance.

Other examples of conditions which may require pre-viable maternal-fetal separation include, but are not limited to, cardiovascular collapse, cardiovascular disease New York Heart Association Class III and IV with current hemodynamic compromise, active massive hemorrhage with significant anemia, and acute fatty liver of pregnancy. A list and explanation of a majority of these conditions can be found in the article “What is NOT an Abortion.”[1] The presence of any of these diagnoses alone does not serve as the sole indication for the separation of the mother and her embryo or pre-viable fetus. All clinicians make their best professional judgment based not only on the degree of life-threatening compromise imposed by these conditions in the individual clinical scenario, but also on the resources available at the healthcare facility, alternative management options, advice provided by maternal-fetal medicine

and neonatology specialists, transfer options, and their individual skill sets.

The mother must also have the ability to consent to or decline separation, based on a robust understanding of the consequences of both action and inaction, as part of the informed consent process and shared decision-making. Both separation and non-separation in these life-threatening situations can result in moral injury to both the patients and the medical professionals involved in the management of these cases. There is a need for hospital systems to create a mechanism for follow-up and support for both the family and the medical staff after these traumatic cases.

Methods of accomplishing a pre-viable separation

Having established that the principle of double effect clearly applies in situations where both a mother and her embryo or pre-viable fetus are at high risk of death if separation does not occur, the next important question is how the separation is to be accomplished. Are all methods of separating the mother and her living pre-viable fetus ethically good or neutral?

Ectopic pregnancy

In 93% of ectopic pregnancies, there is no fetal corpus with a heartbeat found with ultrasound.[11] This may be because the embryo is too small to be detected with ultrasound. AAPLOG recommends that informed consent be obtained from the patient regarding all treatment options, including salpingostomy, salpingectomy, or medical treatment (if clinically appropriate), along with a discussion of the probable effects of each treatment on future fertility. Treatment should be based on shared decision-making, in accordance with the current standard of care.

In 7% of cases of ectopic pregnancy, there is a fetal heartbeat[11] and therefore a known living embryo. In these situations in particular, AAPLOG recommends that all care be given to separating the mother and her embryo or fetus and placenta with the goal of least damage to the embryonic or fetal corpus (as long as doing so does not significantly increase the risk to the mother), in order to uphold the dignity of the embryonic or fetal human being.

Separation procedures for other conditions

Induction of labor

As an augmentation of the natural process of separation, induction of labor as a means of separating the mother from the placenta and living embryo or pre-viable fetus is ethically acceptable in situations in which there is a threat to maternal life. This method also has the advantage of allowing a mother and family to hold their intact child, thereby aiding the grieving process, and it acknowledges the place and relationship of that child within the family.

Suction Dilation and Curettage (D&C) or Dilation and Evacuation (D&E)

In situations where the embryo or fetus is no longer alive, the clinician should proceed in the most expeditious manner to separate the mother from her embryo or fetus and

placenta to prevent maternal death and morbidity.

In truly emergent situations such as massive hemorrhage or sepsis and ongoing resuscitative measures, with the need for expedient maternal-fetal separation in which there is no time for an induction of labor and it is certain or presumed that the embryo or fetus is still alive (for example, if cardiac activity is detected with ultrasonography), then ethically licit decisions must be made quickly to save the life of the mother. There are in general two viewpoints amongst pro-life physicians and bioethicists concerning performing a D&C or D&E in truly emergent life-threatening situations with a living embryo or pre-viable fetus in which all other options have been exhausted.

Some would not perform a D&C or D&E; they assert that these procedures violate the first condition of the Principle of Double Effect because the action itself, suctioning or curetting the contents of the uterus, is an indiscriminate act which primarily and directly destroys the embryo or fetus. Therefore, it is not a morally neutral or good act. The principle is also violated because the good effect, saving the mother's life, flows from a bad effect, the indiscriminate action taken against the innocent embryo or fetus.

Others would intervene with a D&C or D&E to save the mother's life and assert that the Principle of Double Effect is satisfied if one considers the action of emptying the uterus to be a morally neutral action. The death of the fetus, while foreseen, is not the intention or the means by which the mother's life is preserved.

If so, two effects would result from the act:

1. The cessation of hemorrhage or infection by removing the contents of the uterus
2. The death of the embryo or fetus, which is unintended

AAPLOG acknowledges that there may be moral injury associated with either choice. In one circumstance, the physician dismembers a living embryo or fetus in hopes of saving the mother. In the other circumstance, the physician chooses not to dismember a living embryo or fetus despite the impending death of both patients.

Hysterotomy

In cases of need for emergency separation after 14 weeks of gestation, hysterotomy is an ethically acceptable method of separating the mother and her *living* pre-viable fetus under emergent circumstances as discussed above, providing that both the physician and the patient weigh the risks and the short- and long-term morbidity associated with this major surgery (including the need for late preterm Cesarean deliveries of future pregnancies and risk of uterine rupture), and the mother gives her consent. As with induction, hysterotomy allows for respect for the preborn child without direct feticide and allows for the delivery of an intact child to hold and to bury in order to aid the grieving process. This may be a significant consideration for families and should be considered.

Frequently Asked Questions

Q *Does the Principle of Double Effect apply to selective reduction of multifetal pregnancies?*

No. Selective reduction is the intentional destruction of a human life to decrease the risk to another human life. The mother's life is not in immediate jeopardy, nor are the lives of the siblings. The direct killing of a human person without proportionate benefit is intrinsically unethical and cannot be justified by the Principle of Double Effect. For a more thorough explanation of the ethical and medical considerations surrounding selective reduction, see AAPLOG's Practice Guideline on Fetal Intervention and Selective Reduction.[12]

Q *Is it ethically acceptable to end a pregnancy for a life-limiting fetal anomaly without a maternal indication?*

In the situation where a fetus is diagnosed with a condition that is anticipated to result in little to no extra-uterine life, the terminology "potentially life-limiting fetal condition" should be used rather than "lethal anomaly," "incompatible with life," or "fatal fetal anomaly." Given that a fetal human being with a heartbeat is presently alive, the latter terms are misnomers. Additionally, the terms "lethal" and "fatal" overlap with the concept of medical futility and can hinder clear communication and counseling. The terminology "potentially life-limiting" is preferred compared to "not compatible with life" or "nonviable" when referring to conditions which may shorten life before or after birth.

In the case of a potentially life-limiting fetal condition, there is usually no maternal risk to continuing the pregnancy to term. Since the baby is clearly alive, separation for the sole indication of a potentially life-limiting fetal condition becomes a self-fulfilling prophecy, since pre-viable separation will be lethal for that fetus, and post-viable separation at the edge of viability will further decrease the chances of the neonate's survival. Premature separation must not be done with the intent to hasten the death of the baby, but may be indicated if justified by significant and proportionate risk to the mother that cannot be averted in another way.

Many conditions which have historically been judged as "incompatible with life," such as Trisomy 13 and 18, can result in the child's survival for years if the neonate receives appropriate care.[13-15] In fact, one study demonstrated that the single most important independent factor related to mortality before going home or before one year (even after correcting for other factors) was a prenatal diagnosis. The authors contend that children with Trisomy 13 or 18 who did not have a prenatal diagnosis and were treated like any other child until a diagnosis was made may have gained a survival advantage.[16]

Separating the mother and her fetus in the case of a potentially life-limiting diagnosis, if the purpose of the separation is to

hasten the death of the child, is an induced abortion.

As is true in the case of pediatric or adult life-limiting diagnoses, it is not the role of the physician to shorten the life of one person for the alleged mental, emotional, or social benefit of another. AAPLOG empathizes with every mother who experiences the complicated grief that includes not only the potential imminent death of her baby, but also the loss of a healthy pregnancy and all the expectations that go with it. We recommend specialized ongoing multidisciplinary medical, psychosocial, and spiritual support for the maternal patient and her family throughout pregnancy, delivery, and beyond. There is no evidence that a pre-viable induction shortens the grief process inherent in these situations. The physician can and should act in accord with Hippocratic duties by helping the maternal patient (and her family) to celebrate the life of her child, however long or short that life may be, and to provide resources for the family to cope with their grief.

Summary of Recommendations and Conclusion

The following recommendations are based on good and consistent scientific evidence (Level A):

1. Medical conditions exist in which the continuation of pregnancy endangers a pregnant woman's life or threatens serious, irreversible impairment of a major body system. Such situations may necessitate pre-viable maternal-fetal separation in order to avoid the death of both the mother and the baby, even when such a separation will foreseeably lead to an inevitable fetal demise, although fetal demise is not intended.
2. In cases of need for emergency separation, hysterotomy (at the appropriate gestational age) is an acceptable method of separating the mother and her living pre-viable fetus, provided that both the physician and the patient weigh the risks and short- and long-term morbidity associated with this procedure, and the mother gives informed consent. Hysterotomy is a rapid alternative to a multi-day induction of labor. Hysterotomy respects the bodily integrity of the fetal human being. In the peri-viable period, hysterotomy allows for neonatal resuscitation. In clinical scenarios where there is time and no medical contraindications to labor and vaginal delivery, induction of labor should be the preferred method of intervention in situations where pre-viable separation must be performed.

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