WHAT A NEW STUDY TELL US ABOUT LATE-TERM ABORTION AND BABIES "BORN ALIVE" AFTER ABORTION IN IRELAND

A study from UCC recording the experiences of 10 fetal medicine specialists providing abortions for fetal anomalies in Irish maternity hospitals was **published** in the British Journal of Obstetrics and Gynecology.

The testimonies of doctors providing these late-term abortions make for grim reading.

"STABBING THE BABY IN THE HEART"

- Doctors confirmed that feticide – a method of late-term abortion – is being carried out in Irish maternity hospitals.
- According to the Royal College of Obstetricians and Gynaecologists (RCOG) feticide is carried out after 21 weeks and 6 days gestation to ensure there is "no risk of a live birth".
- The RCOG **cautions** that failure to perform feticide in a late-term abortion for a baby with a severe anomaly "could result in a live birth and survival, which contradicts the intention of the abortion".
- A study **published** in the BJOG on feticide clarifies that potassium chloride is injected into the baby's heart to induce a fatal heart attack. The administration of potassium chloride is considered so painful that the authorities in charge of USA executions consider it necessary to firstly administer an anaesthetic and/or a paralytic to avoid suffering to the prisoner being put to death.
- There appears to be no such obligation to administer similar pain relief to babies being put to death in late-term abortion. In fact, Simon Harris refused an amendment which would mandate pain-relief for the baby in late-term abortions.
- One doctor in the UCC paper described carrying out feticide as 'stabbing the baby in the heart'

BABIES 'BORN ALIVE' AFTER TERMINATIONS – DOCTORS 'BEGGING FOR HELP'

- The study reports that doctors experienced conflict with colleagues "regarding the diagnosis of FFA [fatal fetal anomaly], the provision of feticide and palliative care to infants born alive following termination of pregnancy (TOP) for FFA." This

conflict seems to be based around the desire of neonatologists to mandate feticide.

- Doctors said it was “unclear as to who will look after these babies” if a baby is born alive following an abortion. They said this situation resulted in them “begging people to help” them in providing palliative care.
- Doctors said that in the absence of “universal feticide” palliative care was needed for babies who were born alive after termination of pregnancy.
- The report notes that an added difficulty here is that “Ireland’s legislation is without gestational limits and so creating the opportunity for late TOP for FFA.”
- TDs proposed an amendment to abortion legislation in 2018, ensuring that babies born alive after abortion would be guaranteed medical care. Simon Harris refused the amendment.
- We have written to the study authors to ask them to confirm if a situation has occurred in which an infant was born following an unsuccessful abortion and was refused palliative care as is suggested by the study.
- This situation is not uncommon in other countries based on the type of abortion utilized. Statistics Canada records **indicate** that in one 10 year period, there were 491 ‘live-birth’ abortions after 20 weeks gestation.

IMPACT ON DOCTORS CARRYING OUT LATE-TERM ABORTION

- Doctors reported they found performing these late-term abortions to be “a psychological burden”.
- One described feticide as “stabbing the baby in the heart”.
- Others said it was “brutal”, “awful” and “emotionally difficult”.
- “I remember getting sick out in the corridors afterwards because I thought it (feticide) was such an awful procedure and so dreadful,” one doctor told the study.

SUGGESTED APPROACH

The Minister for Health should be asked to investigate and report on whether babies born alive after abortion are receiving medical care, including life-saving medical care.

A ban on feticide should also be proposed: in an emergency if the baby is induced, good medical care should be mandated.

REFERENCES

See the study here: https://pubmed.ncbi.nlm.nih.gov/32935467/

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complicated by FFA

Results: Four themes were identified; 'not fatal enough, 'interactions with colleagues', 'supporting pregnant women' and 'internal conflict and emotional challenges'. FMS feared getting a FFA diagnosis incorrect due to the media scrutiny and criminal liability associated with the TOPFA legislation. Challenges with the ambiguous and 'restrictive' legislation were identified that 'ostracised' severe anomalies. Teamwork was essential to facilitate opportunities for learning and peer support. However, conflict with colleagues was experienced regarding diagnosis of FFA, provision of feticide and palliative care to infants born alive following TOPFA. Participants reported challenges implementing TOPFA, including the absence of institutional support and 'stretched' resources. FMS experienced internal conflict and a psychological burden providing TOPFA, but did so to 'provide full care for women'.

Conclusions: Our study identified challenges regarding the suitability of the Irish legislation for TOPFA and its rapid introduction into clinical practice. It illustrates the importance of institutional and peer support as well as the need for supportive management in the provision of a new service.

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Interactions with colleagues

Almost all FMS identified that a good working relationship with MDT members was 'essential' to provide good quality care. Over half of the FMS identified midwives as 'essential'; they were 'more available' and 'better' in supporting women. Teamwork benefitted the FMS directly as local and national colleagues acted as both a source of learning and peer support. Nearly all FMS identified the need to 'debrief' with those who understand their challenges as 'very important' for their self-care. Despite identifying the need for collaborative working, nearly all participants experienced 'conflict' or 'opposition' when discussing the fatality of conditions. Half of the FMS described meetings as 'divisive' involving 'contentious cases'. They shared that there was 'a massive uncomfortableness' and 'suspicion' with TOP. Over half of the FMS experienced conflict with Neonatologists. Participants reported frustration that these colleagues would engage in decision-making for TOP for FFA but refuse to care for the woman and her baby 'if the driving force was termination'. This generated concern for FMS as they are 'unclear as to who will look after those babies' if a baby is born alive following TOP by induction of labour and without feticide, resulting in them 'begging people to help' them in providing palliative care.

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Internal conflict and emotional challenges

Internal conflict was experienced by almost all FMS as a result of caring for women with a FFA, they expressed having 'a line' that they 'do not cross', and that the condition being terminated is a 'significant abnormality'. Over half of the FMS expressed internal conflict due to the provision of feticide and the need to 'separate yourself from it completely'. They described feticide as 'brutal', 'awful' and 'emotionally difficult' referring to it as 'stabbing the baby in the heart' and held themselves responsible for the death of the baby: 'I caused the death'. However, almost all FMS justified providing TOP for FFA or feticide because it was a 'kindness in some cases' and they would want someone to 'step up and just be kind'. FMS felt obliged to provide TOP for FFA as it is 'the right thing to do' and expressed the importance of being in a position to 'provide full care for women'.

Providing TOP for FFA created a 'psychological burden' for over half of the FMS. A couple referred to themselves as 'doctor death', dealing with death and dying or with opinions from others that they 'are trying to terminate everything'. Half of the participants expressed that this however was their job, that they have 'chosen' 'to support (parents)' and 'it's important to do it well'.

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FMS within this study shared experiences of opposition from colleagues relating to decision-making on the fatality of conditions. Dommergues et al. (2010) suggests, in all countries where TOP for FFA is legalised, interpretation of the legislation is feasible.[32] Where criminal liability of clinicians exists, as it does in Ireland, the UK and throughout the US,[33] there is a potential for conservative interpretations of legislation leading to service provision inconsistencies.[34] Power et al. (2020) identified the need for a universal definition, to include an accurate description of a FFA that results in perinatal death to aid diagnosis, reduce subjectivity and standardise healthcare provision.[30] Furthermore, FMS described Neonatologists' refusal to provide perinatal palliative care to the baby following a TOP by induction of labour and without feticide, with some of the FMS sharing pressures experienced from Neonatologists to conduct feticide. FMS identified these experiences as a source of tension and conflict as they identified that in the absence of universal feticide, perinatal palliative care is warranted for these cases, but are left 'begging' for support to ensure its delivery. While the majority of TOP for FFA occur within the second trimester, before viability[35], unfortunately, some pregnant women within Ireland are without universal access to anomaly scans and so are at risk of a late diagnosis.[13,36] Additionally, Ireland's legislation is without gestational limits and so creating the opportunity for late TOP for FFA. However in other jurisdictions feticide is not a legal requirement, unless requested by the parents, for fetal anomalies not compatible with survival.[37] Despite this, approximately 1-2% of UK terminations in 2018 were confirmed having no feticide[38]. FMS within this study expressed internal conflict regarding TOP for FFA and in particular, around feticide. The balancing of moral and ethical beliefs is universally identified among FMS providing TOP[39-41] and Obstetricians throughout Europe acknowledge the need for more resources and emotional support when providing late TOP.[42]

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Internal conflict and emotional challenges:

To be honest, I struggled with this quite a bit. But I've seen so many women traumatised in this situation, the fatal fetal and lethal, LLCs (life-limiting conditions), that I think the right thing for that group is to offer this treatment in Ireland

It is always very sad and emotional, it is difficult but something that I guess I have been doing for a long time and I am aware that I am doing it for a long time. It doesn't necessarily mean it is easier, it is always very sad

I remember getting sick out in the corridors afterwards because I thought it (feticide) was such an awful procedure and so dreadful

You have to see the positive in it otherwise you would drive yourself mad

Ultimately you feel some degree of positivity if you get people through. And then if you see them back in another pregnancy and they've made it and so on, that's good