

An ethically justified practical approach to offering, recommending, performing, and referring for induced abortion and feticide

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★ EDITORS' CHOICE ★

Induced abortion and feticide continue to be ethically controversial and challenging in medical practice.^{1,2} Whereas the American Medical Association³⁻⁸ and the American College of Obstetricians and Gynecologists⁹⁻¹² provide general ethical guidance, there is a need for practical, comprehensive, ethical guidance for physicians on when to offer, recommend, perform, and refer pregnant patients for induced abortion or feticide. To be comprehensive, guidance should be precise in its terminology and consider 3 core ethical concepts: respecting the autonomy of the pregnant woman, respecting the fetus as a patient, and respecting the individual conscience of the physician. Failure to consider all 3 is inadequate. We set out an ethical framework that incorporates all 3 ethical concepts and then apply that framework to provide practical guidance for offering, recommending, performing, and referring for induced abortion and feticide. The distinct ethical dimensions among them require that these 4 aspects of induced abortion and feticide be considered individually.

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We provide comprehensive, practical guidance for physicians on when to offer, recommend, perform, and refer patients for induced abortion and feticide. We precisely define terminology and articulate an ethical framework based on respecting the autonomy of the pregnant woman, the fetus as a patient, and the individual conscience of the physician. We elucidate autonomy-based and beneficence-based obligations and distinguish professional conscience from individual conscience. The obstetrician's role should be based primarily on professional conscience, which is shaped by autonomy-based and beneficence-based obligations of the obstetrician to the pregnant and fetal patients, with important but limited constraints originating in individual conscience.

Key words: abortion, beneficence, ethics, feticide, fetus as a patient, individual conscience, professional conscience, respect for autonomy

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Precision of terminology

The terms abortion and feticide are often used without precision. Failure to be clear about their precise meanings hobbles any attempt at ethical analysis. We believe in the clinical relevance of the ancient Chinese proverb, "The path to wisdom begins by calling things by their right names."

Abortion and feticide have precise, descriptive, medical meanings. When used with precision, they can and should be distinguished from each other. According to Stedman's Medical Dictionary, abortion is the "[e]xpulsion from the uterus of an embryo or fetus before viability."¹³ Abortion can occur spontaneously or be induced. Induced abortion, because it occurs before viability, will result in the death of the embryo(s) or fetus(es). Feticide is defined as the "[d]estruction of the embryo or fetus in the uterus"¹³ independently of gestational age and is not determinative whether the uterus is emptied. Feticide can be performed by such means as injection of potassium chloride or ligation of the umbilical cord.^{10,14}

Multifetal pregnancy reduction is the use of feticide to cause the death of an

embryo(s) or fetus(es), which typically remains in the ongoing pregnancy.⁹ The more precise terminology is selective feticide because of the vagueness of the word reduction, especially for lay audiences. The word reduction masks the fact that the procedure is feticide, as the means to reduce the order of pregnancy. The termination of pregnancy is the "[i]nduced ending of a pregnancy"¹³ independently of gestational age and is not determinative of whether survival occurs. In light of this definition, selective termination can be confusing and should not be used because selective feticide does not end the pregnancy of the surviving fetus(es).

In this paper, we use the term induced abortion rather than simply the term abortion to be precise that spontaneous abortion is not included. We use the term feticide with the aforementioned meaning. Both induced abortion and feticide are value-neutral, medical terms. Having clarified their precise medical meanings, we are now in a position to analyze their ethical significance in the context of the ethical framework we now describe.

Ethical framework

Respecting the autonomy of pregnant women

The ethical principle of respect for autonomy requires the physician to provide patients with clinical information that they need and then acknowledge and carry out the value-based preferences of the adult, competent patient unless there is compelling ethical justification for not doing so.^{15,16} The pregnant patient brings to her medical care her own perspective on what is in her interest, and there is evidence that pregnant women can use clinical information to make scientifically sophisticated decisions.¹⁷ Because each pregnant patient's perspective on her interests is a function of her values and beliefs, it would be inappropriate for the physician to specify for her what her values should be.¹⁶

Respecting the fetus as a patient

The ethical concept of the fetus as a patient is essential to obstetric clinical judgment and therefore to the informed consent process for induced abortion and feticide.¹⁶ Being a patient means that one is presented to the physician and there exist clinical interventions that are reliably expected to result in a greater balance of clinical benefits over harms.¹⁶ The ethical principle that directs physicians to seek such clinical outcomes is beneficence.^{15,16}

Because of the immaturity of the fetal central nervous system, the fetus lacks the capacity to generate a perspective on its interests. The ethical principle of respect for autonomy and the concept of autonomy-based rights therefore do not apply to the fetus. The ethical concept of the fetus as a patient does not require appeal to the discourse of fetal rights.^{18,19} This is 1 of the concept's main advantages because it prevents ethical analysis of induced abortion and feticide in medical ethics from being paralyzed by divisive debates about a fetal right to life that have been going on for decades, indeed centuries, without any basis for resolution.¹⁶

Beneficence-based obligations to the fetus exist when the fetus is reliably expected later to achieve moral status as a child and person. The clinical application of the ethical concept of the fetus as

a patient therefore depends on links that can be established between the fetus and its later achieving such moral status.¹⁶

The viable fetal patient

One such link is viability, which should be understood in terms of both biological and technological factors.²⁰ When a fetus is presented to the physician and when it is of sufficient maturity that, given the availability of biotechnological support, it can survive into the neonatal period and later achieve moral status, the fetus is a patient.

Biomedical and technological capacities are different in different parts of the world. As a consequence, there is no worldwide, uniform gestational age to define viability. In developed countries viability occurs at approximately 24 weeks of gestational age.^{20,21}

Some viable fetuses will be diagnosed to have severe anomalies. There is certainty or very high probability of a correct diagnosis and either certainty or a very high probability of death as an outcome of the anomaly diagnosed or certainty or a very high probability of severe irreversible deficit of cognitive developmental capacity as a result of the anomaly diagnosed.^{22,23} When these 2 clinical criteria apply, the beneficence-based obligation to protect and promote the fetus' health-related interests has reached its limits. Induced abortion or feticide when these criteria have been met in rigorous clinical judgment does not violate beneficence-based obligations to the fetal patient.^{16,22,23}

The previable fetal patient

The only possible link between the previable fetus and later achieving moral status is the pregnant woman's autonomy. This is because no biomedical technology independent of the woman's body can sustain the life of the previable fetus. The previable fetus has no claim to the status of being a patient independently of the pregnant woman's autonomy. The link, therefore, between a previable fetus and the child and person it can later become can be established only by the pregnant woman's decision to confer the status of being a patient. The pregnant woman is free to withhold, confer, or,

having once conferred, withdraw the status of being a patient on or from her previable fetus according to her own values and beliefs, an important clinical implication of respecting the pregnant woman's autonomy.¹⁶

Respecting individual conscience

Professional medical ethics, based on respecting the pregnant woman's autonomy and respecting the fetus as a patient, generates the ethical obligations that every physician has to pregnant and fetal patients. Physicians, however, also have individual consciences, which appeal to sources of morality other than professional medical ethics, such as personal experience, family upbringing, and religion.^{24,25} In contrast to professional conscience, individual conscience is variable because of the striking heterogeneity of the sources of morality that form individual conscience.¹⁸

Professional conscience governs every physician's obligations to his or her patient. Individual conscience governs whether continuing to serve as the physician to a particular patient obligates that physician to act in such a way as to produce intolerable burdens on his or her individual moral convictions, values, and beliefs. Respecting the individual conscience of each individual physician means that some pregnant women cannot become or continue to be patients of a particular physician. Respecting the physician's individual conscience is an indispensable component of the responsible management of the abortion controversy in clinical practice.

Offering induced abortion or feticide

There is no beneficence-based or autonomy-based obligation to routinely offer every pregnant woman induced abortion. Rather, there are specific circumstances in which there is a beneficence-based or autonomy-based obligation to do so, which we now identify and address.

After viability

After viability, there is a beneficence-based prohibition against feticide of viable fetuses without severe anomalies because the beneficence-based obligation to protect the life and health of the fetal

patient remains intact. As a consequence, the physician has beneficence-based obligations to protect the health and life of the viable fetal patient without severe anomalies.

It follows that it is ethically impermissible to offer feticide for viable fetuses without anomalies or with less-than-severe anomalies, such as Down syndrome or achondroplasia. Less-than-severe anomalies do not involve a high probability of death or a high probability of the absence or virtual absence of cognitive developmental capacity.^{22,23} The pregnant woman has parallel beneficence-based obligations, which rules out an autonomy-based justification for offering induced abortion or feticide in a viable pregnancy with a less-than-severe anomaly.

When a viable fetus has a severe anomaly, offering feticide followed by termination of pregnancy is ethically appropriate. This is because the beneficence-based obligation to protect the life of fetus that has been diagnosed with a severe anomaly has reached its limits.^{22,23} This means that there is an autonomy-based justification for offering feticide followed by termination of pregnancy in a viable pregnancy with a severe anomaly.

Before viability: beneficence-based justifications

There are 2 beneficence-based justifications for offering induced abortion or feticide before viability. The first is based on reliable clinical judgment that continued pregnancy poses a threat to the health or life of the pregnant woman. Preexisting conditions such as severe cardiac disease or some forms of cancer can pose such threats.²⁶ When the best available evidence supports the clinical judgment that continued pregnancy poses a risk to the pregnant woman's health or life, she should be informed about this matter and offered the alternative of induced abortion.

It is important to appreciate that this beneficence-based justification will evolve over time as new evidence accumulates about the risks of pregnancy to women from preexisting conditions or the complications of pregnancy. Some

women, because of moral convictions about the general moral status of the fetus, will refuse this offer. They should be informed that their refusal increases the risk that their health could be severely compromised and that they could die. The final decision to remain pregnant or to elect induced abortion is determined by the pregnant woman's autonomy and should be respected by the physician.

The second beneficence-based justification for offering feticide before viability is based on reliable clinical judgment that continued pregnancy poses a threat to the life or health of coexistent fetuses, such as is the case in higher-order pregnancies and twin pregnancies in which the continued existence of the anomalous fetus that is causing hydramnios poses a threat to the health or life of the other fetus.

Current evidence supports the clinical judgment that these risks can be reduced by selective feticide.¹⁰ When the best available evidence supports the clinical judgment that continued multifetal, previable pregnancy poses a risk to the other fetus' or fetuses' health or life, the pregnant woman should be informed about this matter and offered the alternative of selective feticide. Some women, because of moral convictions about the general moral status of the fetus, will refuse this offer. They should be informed that their refusal increases the risk that the pregnancy will end before viability without any surviving fetuses or end prematurely after viability with increased risk of infant mortality and morbidity. The final decision to remain pregnant, to elect induced abortion, or to elect selective feticide is determined by the pregnant woman's autonomy and should be respected by the physician.

Before viability: autonomy-based justifications

When the best available evidence supports the clinical judgment that continued previable pregnancy does not pose an increased risk to the health or life of the pregnant woman or fetuses, the justification for offering induced abortion or feticide in specific circumstances is autonomy-based. The justification for not routinely offering induced abortion

or feticide is not based in beneficence-based obligations to the fetus. The justification is based in the beneficence-based obligation to the pregnant woman to prevent the unnecessary psychosocial harm that could result from such routine offers.

There are 4 specific clinical circumstances in which induced abortion should be offered on the basis of respect for the pregnant woman's autonomy. First, some pregnant women will express an interest in an induced abortion. Second, other pregnant women will directly and sometimes indirectly express concern about remaining pregnant or will be concerned about multiple birth and will prefer for economic or other personal reasons to have a singleton pregnancy. Third, a previable pregnancy will be diagnosed with an anomaly. Fourth, a complication occurs that threatens the successful continuation of a previable pregnancy, such as preterm premature rupture of membranes. Physicians should respond to these 4 groups by discussing the option of induced abortion or feticide and explaining time limitations.

In response to the offer of induced abortion, physicians should expect pregnant women to sort themselves into 3 subgroups.²⁷ Some will want to continue the pregnancy because they decide to accept whatever child results. Some will not want to remain pregnant and will elect induced abortion. Some will be uncertain about whether to continue the pregnancy.

Respecting the autonomy of pregnant women means that physicians should respect this self-sorting by limiting their role to providing information that these women can use to resolve their uncertainty. Attempting to bias a woman's decision assumes, falsely, that physicians have the professional competence to decide for a woman with a previable pregnancy that she should or should not remain pregnant.

Nondirective counseling should guide physicians in discussing induced abortion with women with previable pregnancies who remain uncertain. Physicians should refrain from making, suggesting, or implying a recommenda-

tion about continuation or termination of a previable pregnancy. Directive counseling toward continuation of a previable pregnancy based upon alleged benefit to the pregnant woman of providing information about fetal development or showing images of fetal development, to prevent remorse or regret, lacks an evidence base. Such directive counseling is an ethically impermissible distortion of the physician's professional role in the informed consent process.¹⁶

All women should be informed that their decision about termination is time limited, given the availability of induced abortion. In addition, to respect autonomy, the physician should provide frank, evidence-based information about maternal or fetal conditions, even if it is emotionally distressing. Physicians need to make the time available for the sometimes extensive and iterative discussions required to disclose the medical facts and assist the woman to assimilate those medical facts into her decision-making process.

Pregnant women who elect induced abortion or feticide should be assured that ethical and legal obligations of confidentiality will be fulfilled: Others will be informed about the patient's decision only with her explicit permission or, in the case of minors, as required by law.⁴ In rare circumstances, should she elect absolute confidentiality, her husband or partner should not be informed.

Individual conscience does not justifiably place limits on the ethics of offering induced abortion or feticide when the aforementioned ethical justifications apply. There are 2 reasons that this is the case. The first is that every physician's obligation to provide appropriate information in the informed consent process is a matter of professional, not individual, conscience. Second, one cannot predict how women will sort themselves in response to offering induced abortion or feticide.

Subsequent decisions are a function solely of the pregnant woman's autonomy. It is therefore a mistake to think that offering induced abortion or feticide makes the physician somehow responsible for the informed, autonomous decisions of a pregnant patient that may not

be consistent with the physician's individual conscience.²⁸

Recommending induced abortion or feticide

There are 4 categories for which recommendations of induced abortion or feticide are considered. The first is when a maternal condition or treatment of such a condition results in increased risk to the pregnant woman's health or life should she continue her pregnancy. The second is when continued pregnancy without feticide substantially increases the risk to the health or life of fetus(es). The third is when a severe anomaly has been diagnosed. The fourth occurs in complications that threaten the woman's health or life and salvage of the fetus is clinically hopeless.

We will argue that recommendations are not ethically justified for the first 3, but only for the fourth. The ethical issue of feticide as a required component of performing an induced abortion is addressed in the next section.

The first and second categories can be addressed together. The first requires balancing the life and health of the pregnant woman against the health and life of the fetal patient in rare cases, such as some forms of cancer.²⁶ The second category requires balancing the life and health of multiple fetal patients. These judgments at first appear to be purely beneficence-based and therefore within the scope of the physician's professional competence to make recommendations, but on closer examination are not. This is because these judgments involve deciding which health or life is more important. This is ultimately not a beneficence-based judgment but autonomy-based: a broader cultural, religious, and individual judgment of the pregnant woman.

Respecting the pregnant woman's autonomy means that the physician should not bias the woman's decision-making process (eg, by soft-pedaling the benefits or overemphasizing the risks of continued pregnancy). No recommendation of induced abortion or feticide is ethically justified when the woman is undecided about how to balance her and the fetal patient's interests. Individual conscience

is not implicated because physicians are not responsible for the ultimate balancing judgments that pregnant women will make in these tragic circumstances after they've been informed about them by their physician.²⁶

In the third category, given the nature of severe fetal anomalies, one might think that recommendation of induced abortion or feticide would be justified (eg, for anencephaly or trisomy 13). Women with serious moral convictions about the moral status of the fetus, especially women with religious convictions about the sanctity of fetal life, will experience a recommendation of induced abortion or feticide as profoundly disrespectful of their autonomy. They may experience moral distress when offered this alternative but offering an alternative, although distressful, is not profoundly disrespectful of the conscience and convictions of such pregnant women.

In medical practice, recommendations should be given when the scope of concern is limited to life and health (ie, beneficence-based considerations), which is not the case in the management of pregnancies complicated by severe fetal anomalies.

The fourth category is straightforward in beneficence-based clinical judgment. For complications such as previable preterm premature rupture of membranes with chorioamnionitis, the fetal condition is hopeless clinically and the woman's health and perhaps life are in danger. There is therefore no beneficence-based obligation to the fetus, and there is a strong beneficence-based obligation to the pregnant woman to protect her health or life, which justifies a recommendation for induced abortion.

Performing induced abortion or feticide

There are 2 major ethical issues concerning performing induced abortion or feticide. The first concerns the method of terminating the pregnancy. The second concerns whether individual conscience places ethically justified barriers on an individual physician's performing induced abortion or feticide.

Before viability it is ethically permissible in professional medical ethics and therefore in professional conscience to perform an induced abortion. This is because, as explained in previous text, the pregnant woman is free to withhold or withdraw the moral status of being a patient from the previable fetus at her discretion. Induced abortion of the previable fetus in such circumstances therefore does not involve the killing of a patient and is permissible in professional medical ethics.¹⁶ For the same reason, performing feticide in a previable pregnancy is ethically permissible in professional medical ethics.

Pregnant women should not be presumed to understand that expelling the near-viable fetus or a viable fetus with a severe anomaly from the uterus could result in a live birth and that feticide can prevent this outcome. In such circumstances live birth creates an increased risk of preventable neonatal morbidity. There is a beneficence-based obligation of the physician and the pregnant woman to prevent this risk.

Refusal of feticide can also be seen as contradictory because election of termination of pregnancy before viability means that the pregnant woman does not wish to have a child issue from her current pregnancy. Such contradictory thinking suggests significant impairment of autonomous decision making. In such a setting, it is reasonable for the physician to require that the pregnant woman accept feticide as a condition for performing termination of her previable pregnancy.

Performing feticide in this setting also exonerates the physician from being accused of performing a so-called partial-birth abortion. The correct account is that the physician is evacuating the uterus after ethically justified iatrogenic fetal demise.

In the United States, partial-birth abortion has been prohibited by state law, a prohibition recently upheld by the US Supreme Court.²⁹ We emphasize that partial-birth abortion is a purely political phrase and should never become part of medical discourse.³⁰ Partial-birth abortion describes feticide that is used in the course of emptying the uterus rather

than before the uterus is emptied. There is no special ethical challenge involved because the aforementioned analysis of feticide before and after viability applies. Laws prohibiting partial-birth abortion represent an ethically unjustified intrusion into professional medical practice.¹¹

Some physicians may have objections in individual conscience to participation in induced abortion or feticide. Respecting individual conscience means that such physicians should be free to refuse to perform induced abortion or feticide. An important implication of this analysis of individual conscience is that a requirement of residents or fellows to participate in induced abortion or feticide is ethically impermissible. However, a requirement that trainees have an appropriate fund of knowledge about these procedures and an appropriate fund of knowledge and clinical skills in managing their complications is consistent with individual conscience and a matter of professional obligation.¹⁸

Physicians with individual conscience-based objections to induced abortion or feticide must keep in mind, when they refuse to perform the procedure, that individual conscience does not govern the physician's professional role. It is therefore impermissible for the physician, on the basis of individual conscience, to express judgments about the morality of a woman's election of induced abortion or feticide or of colleagues who perform these procedures because doing so is inconsistent with nondirective counseling regarding induced abortion before viability.¹⁶

The obligation of a community to ensure access to termination of pregnancy involves complex and controversial appeals to social justice that are beyond the scope of this paper. Whereas it could be argued that every community has such a social justice-based obligation, social justice itself requires respect for individual conscience and cannot therefore mandate violations of individual conscience. An important exception is termination for pregnancy for maternal indications in a medical emergency, such as obstetric hemorrhage or severe intrauterine infection, conditions for which there is no time to transfer the care

of the pregnant woman to another physician or facility.

Referring for induced abortion or feticide

The ethics of referral for induced abortion or feticide is straightforward for physicians who do not have conscience-based objections to induced abortion. If they do not perform induced abortion themselves, they can make what we call direct referrals.³¹ The referring physician sees to it that the patient will be seen by a colleague competent and willing to perform the procedure.

Direct referral appears not to be an option for physicians with a conscience-based objection to induced abortion or feticide because of the explicit involvement of the physician in the subsequent termination of a pregnancy. To concomitantly respect the pregnant woman's autonomy and the individual conscience of physicians opposed to induced abortion or feticide, we have argued for an obligation to make indirect referral for termination of pregnancy.

Indirect referral is both autonomy based and beneficence based. When it is obligatory to offer induced abortion or feticide, respect for the pregnant woman's autonomy in previable pregnancies requires the physician to inform her that induced abortion or feticide is an option. Beneficence requires the physician to provide information about clinics or agencies, such as Planned Parenthood, that provide competent and safe induced abortion or feticide.

The physician's individual conscience is not violated because whether an induced abortion or feticide subsequently occurs is solely a function of the pregnant woman's autonomy after she visits the clinic or agency of her own accord. The referring physician is therefore not responsible for a subsequent induced abortion or feticide.

In summary, direct referral for induced abortion or feticide is not ethically required but is ethically permissible. Conscience-based objections to direct referral for induced abortion or feticide have merit; conscience-based objections to indirect referral do not.³¹

Conclusion

Ethics is an essential component in defining the physician's role in offering, recommending, performing, and referring for induced abortion or feticide. The comprehensive, practical ethical framework elucidated here respects autonomy-based and beneficence-based obligations to the pregnant woman, beneficence-based obligations to the fetal patient, the professional conscience of physicians, and the individual conscience of physicians opposed to induced abortion or feticide. The physician's role in offering, recommending, performing, and referring for induced abortion or feticide is based primarily on professional conscience, shaped by autonomy-based and beneficence-based obligations of the physician, with important but limited constraints originating in individual conscience. ■

REFERENCES

- Johnson LSM. Abortion II: contemporary ethical and legal aspects: A. ethical perspectives. In: Post SG, ed. *Encyclopedia of bioethics*, 3rd ed. New York: Macmillan Reference USA; 2004:7-18.
- Allen AL. Abortion II: contemporary ethical and legal aspects: B. legal and regulatory issues. In: Post SG, ed. *Encyclopedia of bioethics*, 3rd ed. New York: Macmillan Reference USA; 2004:18-28.
- American Medical Association. E-201 Abortion. Available at: http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/E-2.01.HTM&&s_t=&st_p=&nth=1&prev_pol=policyfiles/HnE/E-1.02.HTM&nxt_pol=policyfiles/HnE/E-2.01.HTM&. Accessed Nov. 2, 2008.
- American Medical Association. E-5.05 Confidentiality. Available at: http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/E-5.05.HTM&&s_t=&st_p=&nth=1&prev_pol=policyfiles/HnE/E-4.07.HTM&nxt_pol=policyfiles/HnE/E-5.01.HTM&. Accessed Nov. 2, 2008.
- American Medical Association. H-5.983. Pregnancy termination. Available at: http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&n_p=T&&s_t=&st_p=&nth=1&prev_pol=policyfiles/HnE/H-5.988.HTM&nxt_pol=policyfiles/HnE/H-5.990.HTM&. Accessed Nov. 2, 2008.
- American Medical Association. H-5.990 Policy on abortion. Available at: http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&n_p=T&&s_t=&st_p=&nth=1&prev_pol=policyfiles/HnE/H-5.990.HTM&nxt_pol=policyfiles/HnE/H-5.992.HTM&. Accessed Nov. 2, 2008.
- American Medical Association. H-5.993 Right to privacy in termination of pregnancy. Available at: http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/H-5.993.HTM&&s_t=&st_p=&nth=1&prev_pol=policyfiles/HOD-TOC.HTM&nxt_pol=policyfiles/HnE/H-5.982.HTM&. Accessed Nov. 2, 2008.
- American Medical Association. H-5995. Abortion. Available at: http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/H-5.995.HTM&&s_t=&st_p=&nth=1&prev_pol=policyfiles/HOD-TOC.HTM&nxt_pol=policyfiles/HnE/H-5.982.HTM&. Accessed Nov. 2, 2008.
- American College of Obstetricians and Gynecologists. Committee on Practice Bulletins. Medical management of abortion. Clinical management guidelines for obstetrician-gynecologists no. 67. *Obstet Gynecol* 2005;106:871-82.
- American College of Obstetricians and Gynecologists. Committee on Ethics. Multifetal pregnancy reduction. ACOG committee opinion no. 369. *Obstet Gynecol* 2007;109:1511-5.
- American College of Obstetricians and Gynecologists Statement of Policy. Executive Board. Abortion policy. Available at: http://www.acog.org/publications/policy_statements/sop0009.cfm. Accessed Nov. 2, 2008.
- American College of Obstetricians and Gynecologists. Committee on Ethics. The limits of conscientious refusal in reproductive medicine. Opinion no. 385. *Obstet Gynecol* 2007;110:1203-8.
- Stedman's Medical Dictionary. Available at: <http://online.statref.com/DictionaryHelp/DictionaryHelp.aspx?type=dictionary&SessionId=E64234MHHTKYZGGZ&prnt=dlo&chwin=false>. Accessed Jan. 25, 2009.
- Royal College of Obstetricians and Gynecologists. Further issues relating to late abortion, fetal viability and registration of births and deaths. Available at: <http://www.rcog.org.uk/index.asp?PageID=549>. Accessed Jan. 22, 2008.
- Beauchamp TL, Childress JF. *Principles of biomedical ethics*. 5th ed. New York: Oxford University Press; 2001.
- McCullough LB, Chervenak FA. *Ethics in obstetrics and gynecology*. New York: Oxford University Press; 1994.
- Nicolaidis KH, Chervenak FA, McCullough LB, Avgidou K, Papageorghiou A. Evidence-based obstetric ethics and informed decision-making by pregnant women about invasive diagnosis after first-trimester assessment of risk for trisomy 21. *Am J Obstet Gynecol* 2005;193:322-6.
- Chervenak FA, McCullough LB. Does obstetric ethics have any role in the obstetrician's response to the abortion controversy? *Am J Obstet Gynecol* 1990;163:1425-9.
- Kurjak A, Carrera JM, McCullough LB, Chervenak FA. Scientific and religious controversies about the beginning of human life: the relevance of the ethical concept of the fetus as patient. *J Perinat Med* 2007;35:376-83.
- Chervenak FA, McCullough LB, Levene MI. An ethically justified, clinically comprehensive approach to periviability: gynaecological, obstetric, and perinatal dimensions. *J Obstet Gynaecol* 2007;27:3-7.
- Tyson JE, Parikh NA, Langer J, Green C, Higgins RD, for the National Institute of Child Health and Human Development Neonatal Research Network. Intensive care for extreme prematurity—moving beyond gestational age. *N Engl J Med* 2008;358:1672-81.
- Chervenak FA, McCullough LB, Campbell S. Is third trimester abortion justified? *Br J Obstet Gynaecol* 1995;102:434-5.
- Chervenak FA, McCullough LB, Campbell S. Third trimester abortion: is compassion enough? *Br J Obstet Gynaecol* 1999;106:293-6.
- Kurjak A, Chervenak FA, eds. *Controversies on the beginning of human life*. New Delhi: Jaypee Brothers Medical Publishers (P) Ltd.; 2008.
- Baker RB, McCullough LB. *The Cambridge world history of medical ethics*. New York: Cambridge University Press; 2009.
- Chervenak FA, McCullough LB, Knapp RC, Caputo TA, Barber HR. A clinically comprehensive ethical framework for offering and recommending cancer treatment before and during pregnancy. *Cancer* 2004;100:215-22.
- Chervenak FA, McCullough LB, Sharma G, Davis J, Gross S. Enhancing patient autonomy with risk assessment and invasive diagnosis: an ethical solution to a clinical challenge. *Am J Obstet Gynecol* 2008;199:19.e1-4.
- Thorp JM, Wells SR, Bowes WA Jr, Cefalo RC. Integrity, abortion, and the pro-life perinatologist. *Hastings Cent Rep* 1995;25:27-8.
- Annas GJ. "Partial-birth abortion" and the Supreme Court. *N Engl J Med* 2001;344:152-6.
- American Medical Association. Council on Ethical and Judicial Affairs. H-5.982 Late-term pregnancy termination techniques. Available at: http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/H-5.982.HTM. Accessed Jan. 22, 2008.
- Chervenak FA, McCullough LB. The ethics of direct and indirect referral for termination of pregnancy. *Am J Obstet Gynecol* 2008;199:232.e1-3.