A framework for ethical decision making in neonatal intensive care

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At our NICU we analysed the status quo of decision-making about withdrawing or withholding intensive care in neonates and concluded that neither decisions by the head of the unit or the most experienced senior doctor, nor strict adherence to national guidelines, nor delegation to the parents or to an ethical committee were satisfactory. We therefore developed a framework for structured decision making and demonstrated its impact on health care and on survival of critically ill neonates.

This discussion group is structured into an “inner circle” and an “outer circle”. The “inner circle” consists of nurses and doctors who are directly involved in the care of the infant. Only they are responsible for the final decision. The “outer circle” consists of medical experts (neurologists, cardiologists, surgeons, etc.), other staff members, medical students and members of the Neonatal Ethics Group. The discussion is led by an independent moderator who is not involved in the care of the infant. He or she is responsible for maintaining the structure of the discussion. Parents do not participate in the discussion round but their way of life and their value system are taken absolutely seriously. They are informed about the proposition of the “inner circle” by the doctor and nurses who have the closest relationship with them and they have to agree.

An external evaluation of 84 sessions over three years revealed a beneficial effect on the quality of the decision making process itself and on the quality of the teamwork in the unit – especially the cooperation between nurses and doctors. Survival time in dying patients was shortened from 2 to 7 days.

Conclusion: The introduction of this framework for structured decision making involving doctors and nurses improved the quality of the teamwork. It shortened futile intensive care, and thereby suffering for both infants and parents.
Is feticide justified?

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Perinatologists face difficult decisions about viable fetus feticide, late-term abortion; they confront limits that ethics and the law impose. Viability is a function of both fetal development and available biomedical technology and skilled personnel to use that technology to supplant immature fetal physiology after premature live birth. Feticide should be performing for all terminations at gestational age of more than 21 weeks and 6 days; the method chosen should ensure that the fetus is born dead. There are several reported methods, the intra cardiac potassium chloride is the recommended method and the dose should ensure that fetal asystole has been achieved. There are two main ethical views regarding the status of the fetus, the one is that the fetus is categorically denied independent moral status. The opposite view supported by the right-to-life movement, holds that the fetus categorically has independent moral status. The law in some nations, such as Israel, for example, specifically excludes the fetus as a person, and therefore there is not of gestational age for termination of pregnancy according to the Act of Abortion 1977. The main indication for feticide is fetal abnormalities. With increasing technology for screening and diagnostic testing for fetal abnormality in pregnancy, many more pregnant women and couples are faced with the decision to terminate a pregnancy often after receiving diagnostic test Results in the second or third trimester of pregnancy.

However, some severe abnormalities are not detectable until gestational ages close to or beyond the threshold of viability for independent life and in those cases feticide should be consider. The first includes instances when it is not in the fetus’s own best interest to live. Second, one must consider instances of fetal anomaly which may not be so severe as to preclude life, but sufficiently severe to cause hardship to interested such third parties as parents, siblings or society at large. The medical, legal ethical and social aspects will be discussed.