**Moral Distress and Feticide: Hearing the voices of maternal-fetal medicine (MFM) physicians**

**ABSTRACT**

We conducted in-depth interviews to investigate maternal-fetal medicine (MFM) physicians’ feelings about their moral thoughts and dilemmas related to providing feticide for later abortion. Fourteen MFM physicians (which constitute approximately 40% of MFM physicians who perform feticide in the country) from five hospitals in Israel were interviewed during 2018 and 2019. They were recruited via personal acquaintance and snowball sampling. Findings reveal that despite their clear recognition that feticide is a necessary procedure, all describe themselves as suffering from some features of moral distress related to the process. The reasons for these difficulties are rooted in the Israeli law regarding late abortions, as well as in some of the organizational procedures for making this kind of medical decision. They also come from professional and emotional dilemmas that the physicians encounter. The findings reveal a strong need for more open discussions and doubt-sharing with colleagues regarding each case of feticide. These findings build on existing knowledge and may be useful in developing strategies to support clinicians who provide these essential but sometimes difficult services.

**INTRODUCTION**

Terminations of pregnancy are performed in Israel at a relatively low rate compared to European countries (in 2016 there were 99 cases per 1,000 live births, as compared to an average rate of 198 per 1,000 live births in the European Union countries). In 2018, termination of pregnancy committees received approximately 19,500 applications, of which 99% were approved. Sixty percent of pregnancies were less than 7 weeks of gestation. Late pregnancy terminations after 23 weeks of gestation accounted for 1.8% of all pregnancy terminations in 2018, as compared to 1.1% in 2000.1

It is preferable that necessary terminations of pregnancies be performed as early as possible, but fetal abnormalities may not be detected until late in pregnancy. In late termination of pregnancy beyond fetal viability, usually feticide is offered and performed as the first step in the process in order to prevent a situation in which a live baby is born. “Feticide” involves an invasive action, in which an ultrasound-guided needle is inserted through the abdominal wall and uterus and directly into the blood circulation of the fetus. A potassium salt solution is administered and causes immediate cessation of the heartbeat. The procedure is usually performed by an obstetrician specializing in maternal-fetal medicine (MFM).

In Israel, there is no gestational age limit for termination of pregnancy. A woman interested in termination of pregnancy is referred to a pregnancy committee consisting of a gynecologist, social worker, and another physician.2 However, from the 23rd week of pregnancy onwards, the permission of a special committee is required. For these requests, the committee discusses the circumstances of the request as required by the law. The criteria for approving late termination of pregnancy include severe fetal malformation (i.e., the fetus has more than 30% probability of suffering severe physical or mental disability), pregnancy outside marriage or due to forbidden relations, maternal physical or mental disability, maternal age less than 17 or greater than 40, life endangerment due to continuation of pregnancy, or maternal physical or mental harm.3

Obstetric ethics is sometimes represented by polarized views. One extreme asserts the rights of the fetus as the overpowering ethical consideration, while another extreme asserts the pregnant woman’s rights as the overpowering ethical consideration. A third view emphasizes the importance of medical science and compassionate clinical care of both the pregnant woman and the fetal patient.4 Many argue the ethical grounds for late termination of pregnancy exist only in cases with very strong evidence of a severe fetal abnormality that could prevent the survival of the infant or cause severe physical or mental handicap. In situations of suspected fetal anomalies, the most intricate dilemmas arise when the prognosis is uncertain, or the diagnosis is severe but not necessarily life-threatening.

Although the procedure is anchored in law, its availability ultimately depends on the consent of the performing physician, since by virtue of its technical and psychological complexity, every physician is given the opportunity to refuse to perform the operation. This ability to refuse to carry out the procedure coupled with the need to preserve the procedure to protect human rights in general, and the right of the woman to bodily autonomy in particular,5 creates psychological pressure and moral distress among physicians who provide this service.6

Most studies in this field have been conducted from the point of view of the woman, or the couple, who are undergoing the process.7 Less attention has been given to the impact of feticide on the physician. A minority of works examined the feelings, thoughts, and worldview of the staff in the context of termination of pregnancy.8 The desire to examine deeply and qualitatively the experiences of providers who perform feticide stems from the need to understand how to better support them in providing a procedure that is fraught with high emotional and mental stress but is necessary and important.9 It is also important to recognize that feticide can generate a stress response among the medical staff10 and that moral distress can impact the quality of care provided.11 The issue of understanding stressful situations in the work environment and their impact on physicians’ mental health is a burning issue that has not yet been sufficiently researched in this particular context.12

**Moral distress**

For moral distress to occur, a case must arise in which the physician (or other caregivers) recognizes a moral issue and believes she or he is responsible for her or his own actions in the situation. In addition, the clinician perceives an obstacle to acting on her or his deeply held beliefs or professional obligations .13

Clinical care involves an interfacing of clinical situations with multiple moral actors, including patients, family members, and clinicians, each of whom holds a perspective on good and bad, right and wrong, and desirable and undesirable, and whom exercises judgments about the degrees and relative weight of each.14 In the medical literature, this term is mostly defined as moral distress.15 Moral distress is defined as ‘negative feelings that arise when one knows the morally correct response to a situation but cannot act accordingly because of institutional or hierarchical constraints.’16 In discussing moral distress, there is often a distinction between moral distress and other feelings such as moral uncertainty, moral conflict, and emotional distress.17 An individual may experience moral distress after compromising her or his values, which are the bases of a person’s moral agency. If these compromises are negative and repetitive, healthcare professionals can find themselves desensitized to moral distress or withdrawing from the perceived source of the injury.18

Making moral decisions is fairly common in medical practice, and it is therefore expected that competent and caring clinicians will sometimes disagree regarding aspects of patient care.19 A realistic expectation is that doctors will be heard and that their experiences, expertise, and insights will be thoughtfully considered; it is not believed that moral angst or suffering be altogether prevented.20

Researchers have described the unique features of moral distress. In the present study, we chose to follow Dudzinski’s21 “moral distress map,” which features structures typical of moral distress (see Table 1).

|  |  |
| --- | --- |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

Combined with these features of moral distress, we cannot overlook its emotional features. Very often people identify and describe their angst, frustration, and guilt, as well as their professional burnout, long before they identify them as caused by moral issues .22

The main objective of this study is to examine the experiences of MFM physicians who perform feticide in order to better understand how to support them in performing an action that is described as highly emotional and often controversial while also being necessary and recurring.

**METHODOLOGY**

The research question involved exploring the lived experiences of MFM specialists and the meanings they relate to their experiences performing feticide. Qualitative research methods were most suitable for capturing the perspectives of the participants, their emotions, and the personal meanings they attach to their conduct.23 Recently, qualitative research methods using interpretive analysis have been widely used to explore health professionals’ experiences, attitudes, perceptions, and moral dilemmas regarding their work.24

We developed an in-depth, semi-structured interview guide that consisted of open-ended questions in order to gather personal and professional experiences performing feticide. The questions invited the interviewees to describe a case of feticide that they had particular professional, moral, or emotional difficulty performing; another question asked them to describe the personal norms they have developed regarding interpersonal relations (or lack thereof) with the patient before, during, and after the procedure. The interviewees were also asked to elaborate on their moral thoughts and dilemmas regarding the provision of feticide.

We received IRB (YVC EMEK 2018-26) and Helsinki approval from [REMOVED FOR BLINDED REVIEW] hospital research committee (0018-18-EMC 2018). All participants signed an informed consent form. All personal details were changed to protect the participants’ identities, as the MFM community in Israel is very small.

**Recruitment**

The first author, who is an MFM specialist, facilitated recruitment of the interviewees. She approached MFM specialists through personal relationships, as well as through snowball sampling. Those interested in participating were invited to read an information sheet and sign a consent form before arranging the interview. Both researchers conducted (separately) the interviews. A demographics form was completed prior to the interview, but to aid anonymity, the participants were given false names, and other identifying information was blurred.

**Sample**

Fourteen participants (five women and nine men) were recruited across five Israeli MFM units. The participants constitute about 40% of MFM specialists who perform feticide in Israel. Qualitative research methods do not advocate a prescribed sample size or aspire for data saturation; instead they emphasize the richness of data within each interview.25 The current sample size of 14 is viewed as thorough for qualitative research, allowing for in-depth understanding and rich analysis while incorporating some breadth across participants. Recruiting participants from five different units in five hospitals across the country aided with this breadth.

The inclusion criteria were any MFM specialist currently providing feticide and who had provided this service for at least 5 years. The number of feticides performed per annum ranged from two to 10. Participants were from a variety of ethnicities and religious affiliations.

**Data collection**

Semi-structured in-depth interviews were conducted during 2018 and 2019. The authors conducted two pilot interviews in order to design the interview protocol. These were discussed and corrected to include specific experiences of feticide and factors affecting participants’ professional and personal experiences. Some data from the pilot interviews were included in the final report.

**Analysis**

The aim of this research methodology is to understand the experiences of participants and their interpretations and meaning making. It requires a rigorous four-step approach to the data. Firstly, the researchers read the transcripts closely numerous times in order to get accustomed to the data.26 Secondly, initial themes (e.g., emotional reactions, patterns of meaning) were identified by analyzing the data from both descriptive and tentative interpretive standpoints. Thirdly, initial themes were clustered to superordinate themes across the transcripts, organizing them into master categories. Finally, the researchers re-reviewed all of the transcripts to ensure that the superordinate themes were valid across participants. To ensure that all themes were clearly evidenced in a majority of transcripts, the analysis was discussed throughout with a peer qualitative researcher and a peer MFM specialist. The main themes that were found in the transcripts matched seven (of the eight) features of moral distress described by Dudzinski27 and others.28

**RESULTS**

Analysis of the findings reveal that all physicians who participated in the study experience symptoms of moral distress to some degree, although they do not necessarily define their experiences in that way. Due to the richness of the data, the findings are arranged according to the seven principles identified in Dudzinski’s29 moral distress map, and each is presented below with illustrative verbatim quotations.

1 - Moral responsibility regarding the clinical procedure:30 Researchers have described the person who experiences moral distress as also feeling heightened moral responsibility regarding the clinical procedure he or she is about to perform and the values that underlie this procedure. This is described by Abraham:

“I’m independent in making my professional decisions…The doctor is sovereign to decide that he does not want to terminate lives. Look, we…are killing people. This is not something that is obvious. There are a million questions…I’m not sure that anyone can be coerced to terminate a pregnancy.”

And Michal adds to his words -

“But there are decisions I disagree with. When we talk about risks, we do not know for sure the risk. Especially the late terminations…If there is a couple having a cleft lip and nothing else and they want to have an abortion, in my opinion the committee should not approve. […] and anyway, you cannot diagnose malformations, approve late termination and then “throw” the procedure on someone else! It’s not fair to the patient, it’s not fair to your colleagues! A department that does not provide this service (i.e., feticide) has no right to make the diagnosis and recommendations.”

These quotes, reveal on the one hand a general difficulty in performing the feticide procedure (in the words of Iddo: “It is totally opposite to our professional education”) and a difficulty of having to provide it after someone else’s diagnosis or because the abortion committee approved the procedure. The inner conflict is intensified because Israeli practice allows each physician to determine in each case whether he/she agrees to conduct the abortion. Thus, units and doctors who choose to not provide feticide send their patients to other hospitals or other doctors, which increases both the emotional load for those who do provide feticide and the moral distress regarding the medical decision and its necessity.

2 - The experience of moral distress is directly related to the well-being of a patient; it is not a self-centered experience:31 The literature discussing moral distress emphasizes that it always relates to the patient’s well-being as opposed to the physician’s. However, when we discuss conducting an abortion, there is an overt patient—the pregnant woman—but also a latent patient—the fetus. The well-being of one relates to the termination of the other. Ephraim contemplates the mother’s rights:

“My opinion is not important. I think humans have the right to decide for themselves how they want to live and plan their life. In principle, it does not make me happy. On the other hand, people who have abortions, especially late-term abortions such as feticide, are in dire straits. And there’s the technological means to help them.”

But there is also the side of the latent patient, as described by Iddo:

“They try to escape the needle. It hurts them, surely it hurts them, I’m sure the stabbing hurts them. There are many studies that investigated the stage of development at which embryos start to feel pain. I’m sure in the early weeks they feel pain. It’s terrible to stab them. Or they are trying to resist, trying to escape, which is a horrible sight. It intensifies the tragedy.”

Rakefet adds to Iddo’s painful words and speaks about the feeling of remorse regarding the possible pain she inflicted on the fetus:

“There is always a concern that you may have touched the fetus, and then there are thoughts: What about the pain of the fetus? What exactly do they feel? I have thoughts about the pain I inflict on the fetuses and what they feel, what they do not feel…”

These two descriptions reveal the two sides of caring for the patients related to the procedure, and while Ephraim expresses respect for the mother’s right to choose and her distress, Iddo cannot help but notice the pain the procedure he conducts inflicts on the embryo.

3 - Moral distress is often caused or accompanied by a perception of powerlessness. This can result from rules and regulations regarding a certain treatment, as well as from a lack of sufficient institutional or professional authority to change a clinical course:32 Quite often the doctor who must perform the feticide is not the woman’s caregiver, nor does he or she sit in the special committee that authorized the procedure. In fact, he or she must perform a medical procedure for which she or he was not part of the decision process. In the words of Aharon:

“The moral dilemma in this matter is that we are actually…the decision is not ours. We are just carrying it out…somewhat like a soldier in the military. I do it because I end up feeling I’m being pushed into a corner […] Many times, I go out afterwards with a bad feeling, and I feel it hurts my health because I also often feel a rapid heartbeat and I think something happens inside my body.”

Aharon describes himself regarding some cases of feticide he had to perform as “a soldier in the military,” i.e., that he is obeying orders. He describes the organizational procedure that leads to feticide as making him feel like he is “pushed into a corner.” And he elaborates on Israeli law:

“The law is not ideal. Regarding social abortions—I think it’s pretty weak. I understand that in particular societies an unwanted pregnancy can be life-threatening for the mother […] I think here the law is problematic, it’s unjustified. That it forces us to do too many pregnancy terminations as part of medical care.”

4 - Blame often underlies moral distress. Sometimes the blame is directed toward a person (e.g., chairperson of the department) or entity (e.g., the law). Other times the blame is self-directed, often leading to remorse and guilt. Most of the interviewees blamed Israeli law for being both “too flexible” and at the same time “ambiguous.” Sarit phrases it clearly:

“The State of Israel does not deal with this! On the one hand—” you cannot perform pregnancy terminations,”—on the other—“yes, you have to do terminations, but we will decide when.” “And then again—there is no time limit (i.e., upper gestational age at which you can terminate a pregnancy in Israel)—up to week 40! It’s a spineless approach…There is unbearable flexibility.”

And she concludes angrily: “The state has to come up with some kind of solution that won’t put doctors in a situation where they have to kill healthy babies!”

And Nadav, considering feticide, adds:

“I think doctors should not talk about their work. People don’t understand us. It’s okay because our jobs are weird and extreme and not normal…It’s hard for people to understand…It’s difficult for other people to understand the situations we’re going through.”

It is true that these physicians, and other interviewees in this research, do not explicitly talk about self-blame or shame. However, they describe a real difficulty to discuss this work with others, including their family. Michal says: “I don’t bring these things home. Everything else I will but not this (i.e., feticide). I don’t tell my kids, even though they are grown up. It’s not something I would want to reveal, say it, share it with anyone.”

5 - There are at least two conflicting responsibilities involved: the professional commitment and the ethical obligation:33 Conflicting obligations pose complex moral dilemmas because the situations they evoke are always such that no matter what the doctor chooses to do—one (or more) values are doomed to be compromised. Sarit describes the complexity of the situation:

“I believe that if doctors have a technology and skill then it is not right for them to refuse to use it for the benefit of those who ask for it…On the other hand terminating a healthy fetus—I don’t think it’s fair to ask a doctor to do it. There is a conflict. The fact that we have the skills does not mean that we have to do things that are against our beliefs.”

And yet professional pride also plays a part in this dilemma, as Sharon says:

“Sometimes if the procedure was easier than I expected, I actually feel really proud that it went well. But then I say to myself— ‘look what you’re excited about, you killed a fetus. Why did you become a doctor?’ And I say to myself—‘what did I do, God, I didn’t save anyone’… But then I also say— ‘well, maybe I saved a family.’ You try to tell yourself things like that too.”

However, some of the interviewees are more decisive on this matter, such as Ofer who asserts:

“It is the woman’s body and it is her right to have an abortion. To me, if it is against a doctor’s belief and there is someone else to do it—then he doesn’t have to do it. But if the woman is really distressed, I obviously expect a doctor to see the woman before the fetus.”

6 - Doctors must distinguish between actions that ease their moral distress (such as meditation) and actions that improve the care or experience of the patient. It is the clinician’s responsibility to identify actions that could help the patient.34 This principle resembles principle 2, above, as it emphasizes the obligations of the doctor toward the patient as preceding his/her obligations to him/herself. However, the focus here is not only on awareness (as it is in principle 2) but also on the doctor’s obligation for actions that will help patients. A good example of this principle can be found in the words of Iddo:

“There are ways to make it easier for the patients. For example, putting a curtain in front of a woman so she won’t see what’s happening on the screen. Putting on music, so she will not hear the discussions between us. The husband also does not have to look at the screen. Because the experience of watching such a procedure is terrible to anyone who is inexperienced with it. We approach it as something very technical, busy getting to the right spot, applying all the skills we learned and preforming it professionally. For us, we try to disconnect ourselves. Sometimes we don’t even see the face of the woman…”

And Rakeffet adds:

“They are terribly alone (the couple). I help them as much as I can, but it’s a drop in the sea. And it takes a lot of energy from me. I could see many more patients if mental health professionals would have given them the mental support they need. And it would be a lot easier for me as well. I didn’t choose to be a psychologist; I chose to be a doctor.”

As can be seen in these quotes, the doctors are aware of the difficulties of the patients and feel responsible for trying to help the patients, even at the cost of their peace of mind and efficiency, as described in the words of Rakeffet.

7 - A primary moral goal is not to ease moral distress but to encourage an ethics consultation, not to alleviate moral distress but to identify and address the moral issue(s) that cause it:35 Although moral distress is painful and makes it more challenging for doctors to conduct some parts of their professional obligations toward their patients, most of the interviewees perceived it as an important, albeit difficult, part of their professional path, as well as a means to improve their conduct. As Avraham describes:

“It’s a dilemma, and we have differences of opinion. It’s always an open topic, and it’s impossible to ignore it […] and we shouldn’t ignore it. After all, someone (us) is taking someone else’s life. And not because he did a crime and not because he…just because he’s unhealthy, just because he is not wanted. It’s complicated.”

And Limor concludes:

“We have a dilemma; we are really deliberating on it all the time. In the work group we’ve concluded that for the patients we must make this process more containing. With a spouse or companion inside, a curtain that covers […] But there’s a lot of thinking about the act itself. I think, often because of what you hear from the women. You hear hard things that make us move uncomfortably in the chair.”

**DISCUSSION**

Moral distress is a silent epidemic that undercuts physicians’ efforts to promote professionalism and empathetic medicine.36 Recognizing the ubiquity and impact of moral distress is therefore crucially important. Recent studies found that abortion providers experience considerable ambivalence in their work, as abortions are often regarded socially as a necessary task but often seen as morally dubious.37 In light of the present study’s results, there is no doubt that many of the experiences and feelings that physicians describe relate to ethical issues and the moral distress that arises around the performance of feticide. However, it should be emphasized that all our interviewees recognize feticide as a legitimate clinical procedure and conceptualize the practice of feticide as difficult but necessary.

Recently, there has been much discussion in the medical literature regarding moral distress in the context of various medical issues (such as end of life), but we think that feticide present a unique and extreme situation with far-reaching consequences. In the case of fetal malformation, which was the reason for 90% of late terminations of pregnancies in 2018,38 it is a process of making a decision under uncertain conditions regarding the newborn’s health outcomes. In neonatal medicine, both physicians and families live and make decisions under uncertain conditions, and this is accentuated for fetal prognosis in the face of a diagnosed malformations. Late termination of pregnancy is mostly a decision of the pregnant woman herself and is submitted for approval of a special committee, but the physician who has to perform it is usually not involved and might sometimes feel that the decision is wrong. This clash between the professional values of the physician and the patient’s right to decide regardless of the physician’s opinion may be a root cause of moral distress.39 The Ministry of Health’s position paper from 200740 attempted to define more clearly the outline for late termination of pregnancy for fetal malformation or genetic disorders, stating that as gestational age progresses, the fetus must have at least a 30% probability of having a significant handicap in order to comply with restrictions to justify cessation of life at viability. However, these guidelines cannot always help in the face of uncertainty, and they do not seek to limit the consultations. It seems that the current guidelines deliberately leave some ambiguity to allow a deep examination of every case and its intricacies, both when the reason for seeking termination is fetal malformations and also when the reasons are maternal mental or physical health, possible risk to her life, social causes, and other factors.

Another point that complicates the situation is a decision-making process that is unlike other decisions typically made by a physician and patient. Typically, these professional decisions are based on formal medical knowledge, evidence-based medicine, and the physician’s professional experience. In late termination of pregnancy, the decision is not purely medical, and it is primarily the decision of the pregnant woman and sometimes her partner, and not the physician. Here, the decision is based on the personal values of the patient, her worldview, her beliefs, and her life circumstances.

Medical professionalism has created an expectation for physicians to be in control of the situation as well as of their emotions. Consequently, the internal distress of physicians is often expressed outwardly by withdrawal or detachment from complex situations.41 When physicians cannot identify or name the cause of their distress, they are left with ambiguous anguish without adequate ways to uproot and rectify their feelings.42 A review of moral distress and its implications reveals that moral distress negatively affects clinician’s well-being and job retention.43

Feticide is performed within hospital departments (not private practice) within a healthcare system under state regulations. As such, the issues regarding feticide need to be addressed and openly discussed at each of these levels to allow acknowledgment of its ethical qualities, room for peers’ consultation, and shared responsibility.

Moral distress may often arise from insufficient ethical discussion that incorporates the views of all involved.44 Research45 shows correlation between moral distress and organizational culture. A work environment that facilitates structured ethical discussions, collaborations, and discourse among various caregivers may aid in creating a moral climate where emotions and ethical concerns can be discussed as openly and as constructively as professional and technical concerns.46 We believe this might relieve some of the physician’s sense of burden and reduce burnout.

Abortion providers’ current moral distress, self-censorship, and “avoidance of dangertalk” as Martin et al.47 call it, come with a personal and social cost to all involved. Opening up and reflecting on feticide can reinvigorate the discourse both of the pro-choice movement and its moral meanings (Harris et al., 2011).48 The goals of maintaining a constant ethical discourse in a department’s daily work are three: 1) raising and sharing ethical dilemmas and improving awareness of the subject; 2) emphasizing the primary value of the woman’s right to her body and her pregnancy and of the physician’s commitment to help her in times of distress; and 3) maintaining a high standard of care through an empathetic doctor-patient relationship that is essential to each party. There is an emerging literature into the emotional toll of practicing MFM. Still, more research is needed to further address the impact interventions such as emotional training, support for work-related stress, ethics rounds, supervision, and counseling.

**Table 1.** Typical features of moral distress

|  |  |
| --- | --- |
| Moral distress map | Structural features of moral distress |
| 1 | Feelings of heightened moral responsibility regarding the clinical procedure he or she is about to conduct and the values that underlie this procedure (McCarthy & Deady).\* |
| 2 | The experience of moral distress is directly related to the well-being of a patient; it is not a self-centered experience. The lingering distress and discouragement that endure after episodes of moral distress and the memories and regrets related to a patient are at the center, often resulting in feelings of discouragement and powerlessness (Epstein & Hamric).\* |
| 3 | Moral distress is often caused or accompanied by a perception of powerlessness. This can result from rules and regulations regarding a certain treatment, as well as from a lack of sufficient institutional or professional authority to change a clinical course (Harris).\* |
| 4 | Blame often underlies moral distress. Often a person (e.g., chairperson of the department) or entity (e.g., administration) is blamed and cast as wrong or insensitive. When the restraints are internal, such as a lack of courage or experience, the blame is self-directed, often leading to remorse and guilt (Harris).\* |
| 5 | At least two responsibilities are conflicting; the professional and ethical obligations (Dudzinski).\* |
| 6 | When determining the best course of action regarding the issue causing moral distress, we should distinguish between actions that ease the clinician’s moral distress (such as meditation) and actions that improve the care or experience of the patient. It is the clinician’s responsibility to identify actions that can help the patient (Dudzinski).\* |
| 7 | The primary moral goal is not to ease moral distress. Moral distress may prompt an ethics consultation, but the goal of the consultation should not be to alleviate moral distress, but to identify and address the moral issues that caused it (Dudzinski).\* |

\* J. McCarthy and R. Deady, “Moral distress reconsidered,” *Nursing Ethics* 15, no. 2 (March 2008): 254-62.

E.G. Epstein and A.B. Hamric, “Moral distress, moral residue, and the crescendo effect,” *The Journal of Clinical Ethics* 20, no. 4 (December 2009): 330-42.

L.H. Harris, “Second trimester abortion provision: breaking the silence and changing the discourse,” *Reproduction Health Matters* 16, no. 31 (May 2008): 74-81. doi:10.1016/S0968-8080(08)31396-2.

D.M. Dudzinski, “Navigating moral distress using the moral distress map,” *Journal of Medical Ethic*s 42, no. 5 (May 2016): 321-4. doi:10.1136/medethics-2015-103156.

**NOTES**

1. Information Division, Ministry of Health, 2019
2. “The Penal Law - Termination of Pregnancy 1977” and the regulations for the law of 1980, <https://www.health.gov.il/UnitsOffice/HD/MTI/info/Pages/SPbyLaw.aspx>, accessed 14 January 2018.
3. Ministry of Health: General Director’s note 19/12/07- 23/2007.
4. T.M. Prentice and L. Gillam, “Can the ethical best practice of shared decision-making lead to moral distress?” *Journal of* *Bioethical Inquiry* 15, no. 2 (June 2018): 259-68.
5. D. Amir, *Abortions – a silenced issue in Israel* (Tel Aviv: Resling, 2015).
6. V. Fay, S. Thomas, and P. Slade, “Maternal–fetal medicine specialists’ experiences of conducting feticide as part of termination of pregnancy: a qualitative study,” *Prenatal Diagnosis* 36, no. 1 (January 2016): 92-9.
7. R.D. Leichtentritt, “Silenced voices: Israeli mothers’ experience of feticide. *Social Science & Medicine* 72, no. 5 (March 2011): 747-54.
8. A. Lipp, “A review of termination of pregnancy: prevalent health care professional attitudes and ways of influencing them.” *Journal of Clinical Nursing* 17, no. 13 (July 2008): 1683-88.
9. Amir, “Abortions – a silenced issue in Israel,” see note 5 above; Fay, Thomas, and Slade, “Maternal–fetal medicine specialists’ experiences of conducting feticide as part of termination of pregnancy: a qualitative study,” see note 6 above, pp. 92-9.
10. P.A. eandM. “,”, no. (December 2003)
11. K.M. ,“,”, no. (September-October 2005) -
12. S. et al,“,”Archives of Gynecology and Obstetrics, no. (October 2016):
13. M.C. R.K. M. andT. “,”, no.(January 2001) -; D.M. Dudzinski, “Navigating moral distress using the moral distress map,” *Journal of Medical Ethics* 42, no. 5 (May 2016): 321-4. doi:10.1136/medethics-2015-103156.
14. J.T. Berger, “Moral Distress in Medical Education and Training,” *Journal of General Internal Medicine* 29, no. 2, (February 2014): 395-8. doi: 10.1007/s11606-013-2665-0.
15. Y. andC. “,”, no. (February 2015)-
16. Ibid., 15.
17. J. andR. ,“,”*ing*, no. 2(March 2008) -
18. A.B. andL.J. ,“,”, no. 2 (February 2007):-
19. C.H. A.W. and J.S. ,“,”, no. 9 (September 2013)-
20. A. M. D. andC. “,”, no. 4 (August 2013):-.
21. Dudzinski, “Navigating moral distress using the moral distress map,” see note 13 above, pp. 321-4.
22. M. andJ. ,“,”, no. 2 (January 2007) -
23. J. ,“,”, no. 2(1996) -
24. M. S. M. andM. ,“-,”, no. 9 (September 2002)-; R. Graham, K. Mason, J. Rankin, and S. Robson, “The role of feticide in the context of late termination of pregnancy: a qualitative study of health professionals’ and parents’ views,” *Prenatal Diagnosis* 29, no. 9 (September 2009): 875-81.
25. J. Smith, P. Flowers, M. Larkin, I*nterpretative Phenomenological Analysis: Theory, Method and Research* (London: Sage, 2009).
26. D. Biggerstaff and A. Thompson, “Interpretative phenomenological analysis (IPA): a qualitative methodology of choice in healthcare research,” *Qualitative Research in Psychology* 5, no. 3 September : 173-83.
27. Dudzinski, “Navigating moral distress using the moral distress map,” see note 13 above, pp. 321-4.
28. E.G.
29. Epstein and A.B. Hamric, “Moral distress, moral residue, and the crescendo effect,” *The Journal of Clinical Ethics* 20, no. 4 December : 330-42; McCarthy and Deady, “Moral distress reconsidered,” see note 17 above, pp. 254-62.
30. Dudzinski, “Navigating moral distress using the moral distress map,” see note 13 above, pp. 321-4.
31. McCarthy and Deady, “Moral distress reconsidered,” see note 17 above, pp. 254-62.
32. Epstein and Hamric, “Moral distress, moral residue, and the crescendo effect,” see note 28 above, pp. 330-42.
33. Dudzinski, “Navigating moral distress using the moral distress map,” see note 13 above, pp. 321-4.
34. McCarthy and Deady, “Moral distress reconsidered,” see note 17 above, pp. 254-62.
35. Berger, “Moral Distress in Medical Education and Training,” see note 14 above, pp. 395-8.
36. Dudzinski, “Navigating moral distress using the moral distress map,” see note 13 above, pp. 321-4.
37. G. Lamiani, L. Borghi, and P. Argentero, “When healthcare professionals cannot do the right thing: A systematic review of moral distress and its correlates,” *Journal of Health Psychology* 22, no. 1, (January 2017): 51-67.
38. L.H.
39. Harris, “Second trimester abortion provision: breaking the silence and changing the discourse,” *Reproduction Health Matters* 16, no. 31 Suppl, (May 2008). 74-81. doi:10.1016/S0968-8080(08)31396-2.
40. Information Division, Ministry of Health, see note 1 above.
41. Prentice and Gillam, “Can the ethical best practice of shared decision-making lead to moral distress?” see note 4 above, pp. 259-68.
42. Ministry of Health: General Director’s note 19/12/07- 23/2007, see note 3 above.
43. Prentice and Gillam, “Can the ethical best practice of shared decision-making lead to moral distress?” see note 4 above, pp. 259-68.
44. Dudzinski, “Navigating moral distress using the moral distress map,” see note 13 above, pp. 321-4.
45. Lamiani, Borghi, and Argentero, “When healthcare professionals cannot do the right thing: A systematic review of moral distress and its correlates,” see note 36 above, pp. 51-67.
46. Epstein and Hamric, “Moral distress, moral residue, and the crescendo effect,” see note 28 above, pp. 330-42.
47. J.M. K. J.M. andR.L. “,”, no. (September-October 2013)-.
48. Y.Y.
49. Hu, et al., “Physicians’ needs in coping with emotional stressors: the case for peer support,” *Archives of Surgery* 147, no. 3 (March 2012): 212-7.
50. L.A.
51. Martin, J.A. Hassinger, M. Debbink, and L. Harris, “Dangertalk: Voices of abortion providers,” *Social Science & Medicine* 187, (July 2017): 75-83.