**Moral Distress and Feticide: Hearing the voices of maternal and fetal medicine (MFM) physicians[[1]](#footnote-1)**

**Abstract**

The manuscript describes a study that used in-depth interviews to investigate maternal and fetal medicine (MFM) physicians’ feelings about their moral thoughts and dilemmas related to providing feticide for later abortion. Fourteen MFM physicians (which constitute about 40% of MFM physicians in the country), from five hospitals in Israel were interviewed during 2018-2019. They were recruited via personal acquaintance and via "snowballing". The findings reveal that despite their clear recognition that feticide is a necessary procedure they all describe themselves as suffering from some features of moral distress regarding conducting the process. The reasons for these difficulties are rooted in the Israeli law regarding late abortions, as well as some of the organizational procedures of 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 would 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 1000 live births, as compared to an average rate of 198 in the European Union countries). By 2018, there were about 19,500 women's applications for terminations of pregnancy committees, of which 99 percent were approved. Sixty percent of the pregnancies were before the seventh week of pregnancy. Late pregnancy terminations over week 23, accounted for 1.8 percent of all pregnancy terminations in 2018, as compared to 1.1% in 2000 (Information Division, Ministry of Health, 2019).

Preference is for terminations of pregnancies to be performed if necessary, as early as possible, but there are several instances in which for example fetal abnormalities are only detected until late in pregnancy. In Late termination of pregnancy beyond foetal 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 a needle is inserted through the abdominal wall and uterus of the pregnant woman in an ultrasound-guided manner, directly into the blood circulation of the embryo, through which a potassium salt solution is administered to cause an immediate cessation of the heartbeat. The procedure is usually performed by an obstetrician specializing in maternal and foetal medicine (MFM).

In Israel, termination of pregnancy is carried out without limitation in the law in terms of gestational age. A woman interested in termination of pregnancy is referred to a pregnancy committee consisting of a gynaecologist, social worker, and another physician (Penal Law, 1977). However, from the 23rd week of pregnancy onwards the permission of a special committee is required. There are provisions in the law according to which the committee discusses the circumstances regarding a woman's request for the late termination of pregnancy. The criteria for approving termination of pregnancy include foetal malformation- the foetus has more than 30% probability of suffering severe physical or mental disability, pregnancy outside marriage or due to forbidden relations, a woman with a physical or mental disability, a woman over the age of 40 or before the age of 17, a continuation of pregnancy that may endanger the life of the woman, or cause her physical or mental harm (General Director’s note 19/12/1997- 23/2007).

Obstetric ethics is sometimes represented by polarized views. One extreme asserts the rights of the fetus as the overpowering ethical consideration. 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 (Prentice & Gillam, 2018). 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 the law, the availability of the process ultimately depends on the consent of the performing physician, since by virtue of the complexity of the action technically and psychologically, every physician is given the opportunity to refuse to perform the operation. The possibility of refusing to carry out the procedure on the one hand, and the need to implement it as part of a conception of human rights in general, and the right of the woman to her body in particular, on the other hand (Amir, 2015) creates psychological pressure and moral distress among the physicians who perform this activity (Fay, Thomas & Slade, 2016).

Most studies in this field have been done from the point of view of the woman, or the couple, who are undergoing the process (Leichtentritt, 2011). Less attention has been given to the impact of the action of feticide on the physician ensuing with the feticide action. A minority of works examined the feelings, thoughts, and worldview of the staff in the context of termination of pregnancy (Lipp, 2008). The desire to examine the experiences of the providers who carry out the procedure in a deep and qualitative method stems from the need to understand how to better support them and to allow the execution of an action that is described as fraught with emotional stress and high mental stress, but is necessary and important (Amir, 2015; Fay, Thomas & Slade, 2016). ). It is also important to recognize the action as having the potential to generate a stress response among the medical staff (Promecena & Monga, 2003) as well as the impact of moral distress on the quality of care provided (Gutierrez, 2005). The issue of understanding stressful situations in the work environment and their impact on the mental health of the physicians is a burning issue that has not yet been sufficiently researched in this particular context (Mache et al., 2017).

**Moral distress**

For moral distress to occur, a case must arise in which the physician (or other care givers) 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 his deeply held beliefs or professional obligations. (Corley et al. 2001; Dudzinski, 2016).

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, desirable and undesirable, and whom exercises judgments about the degrees and relative weight of each (Berger, 2013). In the medical literature, this term is mostly defined as Moral Distress (Oh & Gastman, 2015). Moral distress was 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’ (0h & Gastmans, 2015; p. 15). In discussing moral distress, there is often a distinction between moral distress and other feelings such as moral uncertainty, moral conflict and emotional distress (McCarthy & Deady, 2008). 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 (Hamric & Blackhall, 2007).

Making moral decisions is fairly common in medical practice, and it is therefore expected that competent and caring clinicians will sometimes have disagreements regarding different aspects of patient care (Rushton et al., 2013). A realistic expectation is that doctors will be heard and that their experiences, expertise and insights thoughtfully considered; not that moral angst or suffering be altogether prevented (Heino et al., 2013).

Different researchers described the unique features of moral distress. In the present study we chose to follow Dudzinski’s “moral distress map” (Dudzinski, 2016) which features structures typical of moral distress. (See box) -

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| **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, 2008) |
| 2 | The experience of moral distress is directly related to the well-being of a patient. It is not a self-centred experience. The lingering distress and discouragement that endures after episodes of moral distress, the memories and regrets related to a patient are at the centre, often resulting in feelings of discouragement and powerlessness (Epstein & Hamric, 2009) |
| 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, 2008) |
| 4 | Blame often underlies moral distress. Often a person (e.g., chairman 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, 2008). |
| 5 | At least two responsibilities are conflicting professional and ethical obligations. (Dudzinski, 2016) |
| 6 | When determining the best course of action regarding the moral distress issue, we should distinguish between actions that ease the clinician’s moral distress (such as doing 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 (Dudzinski, 2016) |
| 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 cause it. (Dudzinski, 2016). |

Combined with these features of moral distress we did not 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 (Wolkomir & Powers, 2007).

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 on one hand, but on the other hand necessary and recurring.

**Methodology**

The research question involved exploring the lived experiences of maternal–fetal medicine specialists and the meanings they relate to those experiences concerning their conduction of feticide. In order to capture the perspectives of the participants, their emotions and the personal meanings they attach to their conduct we found qualitative research methods as most suitable (Smith, 1996). In the past years qualitative research methods using interpretive analysis have been widely used to explore health professionals’ experiences, attitudes, perceptions and moral dilemmas regarding their work (for example – Garel et al., 2002; Graham et al., 2009; and others).

An in-depth, semi - structured interview that consisted of open questions was constructed by the researchers, in order to gather personal and professional experiences of conducting feticides. The interview questions invited the interviewees to describe a case of feticide that they had a special professional, moral or emotional difficulty conducting; another question asked them to describe the personal means they have developed regarding interpersonal relations (or lack of them) 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 feticides.

The research received both an IRB (YVC EMEK 2018-26), and Helsinki approval from Haemek hospital research committee (#1818). All participants signed an informed consent of participation. All the participants personal details were changed to hide their identities since the MFM professional community in Israel is very small.

Recruitment

The first author, who is a MFM specialist, facilitated recruitment of the interviewees. She approached MFM specialist through personal relations as well as through” snowball” recruiting method. 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 maternal–fetal medicine units. The participants constitute about 40% of MFM specialists in Israel. Qualitative research methods do not advocate a prescribed number for its sample or aspire for saturation of the data, instead of that the richness of data within each interview is emphasized (Smith, Flowers & Larkin, 2009). The current sample size of fourteen for a qualitative research is viewed as thorough, allowing for in-depth understandings and rich analysis while incorporating some breadth across participants. Particularly as they were recruited from five different units in five different hospitals across the country.

The inclusion criteria were any MFM specialist who currently conducted feticides and had performed so for at least 5 years. The number of feticides performed per annum ranged from two to ten. Participants were from a variety of ethnicities and religious affiliations.

Data collection

Semi-structured in-depth interviews were conducted during 2018 - 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 of the data from these interviews were included in the final report.

Analysis

The aim of this kind of 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 (Biggerstaff & Thompson, 2008). Secondly, initial themes (for example – emotional reactions; patterns of meaning; etc.) were identified by analyzing the data from both descriptive and tentative interpretive standpoints. Thirdly, the initial themes were then clustered to superordinate themes across the transcripts, organizing them into master categories. Finally, the researchers moved across all of the transcripts again ensuring that the superordinate themes were valid across the 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 that are described in Dudzinski's (2016) and others' studies (for example – Epstein & Hamric, 2009; McCarthy & Deady, 2008).

**Results**

Analysis of the findings reveal that all the physicians that participated in the study experience to some degree symptoms of moral distress, although they don't necessarily define their experiences in that title. We would like to substantiate this claim using verbatim quotes from the participants. Due to the richness of the data - the findings are arranged according to the seven principles identified in Dudzinski’s moral distress map (2016), and each is presented below with illustrative verbatim quotations.

1 - moral responsibility regarding the clinical procedure (McCarthy & Deady, 2008): Different researchers described the person who experiences moral distress as also feeling heightened moral responsibility regarding the clinical procedure he or she is about to conduct 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 (=of feticide) has no right to make the diagnosis and recommendations".

These quotes, reveal on the one hand a difficulty in conducting the procedure of feticide In general (or in the words of Iddo -"It is totally opposite to our professional education"), and of having to conduct it under someone else's diagnosis or because the abortion committee approved. The inner conflict is intensified because the Israeli practice allows each physician to determine in each case whether he/she agrees to conduct the abortion. Thus, units and doctors that "don't want to do it" send their patients to other hospitals or other doctors which increases both the emotional load for those who conduct 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 (Epstein & Hamric, 2009): The literature that discuss moral distress emphasize that it always pertains to aspects that relate to the patient's well-being, and not 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 on 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 his painful words and tells 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 that are related to the procedure, and while the Ephraim express respect to 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 enough institutional or professional authority to change a clinical course (Dudzinski, 2016): Quite often the doctor who must perform the feticide is not the woman's care giver, nor does he or she sit in the special committee that authorized it. In fact, he or she must carry-out a medical procedure he or she was not part of making. 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 – has to obey orders. He describes the organizational procedure that leads to feticide procedures as making him feel like he is "pushed into the corner". And he elaborates on the 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 towards a person (e.g., chairman 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 the 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 limits (to the week in 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 considers conducting feticide and 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's true that these physicians, and other interviewees in this research, don't 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 (=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 is at least two conflicting responsibilities involved: The professional commitment and the ethical obligation (McCarthy & Deedy, 2008): 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) of his values is 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 (Berger, 2013): This principle resembles principle 2, above, as it emphasizes the obligations of the doctor towards 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 the 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 to try and 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 (Dudzinski, 2016): Although moral distress is painful and makes it more challenging for doctors to conduct some parts of their professional obligations towards 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. Afterall 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 as well as empathetic medicine (Lamiani, Borghi & Argentero, 2017). Recognizing the ubiquity and impact of moral distress is therefore crucially important. Recent studies found that abortion providers experience considerable ambivalence in their work, because abortions are often regarded socially as a necessary task but often seen as morally dubious (Harris, 2008). 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 our interviewees recognize feticide as a legitimate clinical procedure and the practice of feticide is conceptualized 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 performing feticide present a unique and extreme situation with far-reaching consequences. In the case of late termination of pregnancy for the reason of fetal malformation, which was the cause for 90% of the total late terminations of pregnancies in 2018 (Information Division, Ministry of Health, 2019), then 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 regarding fetal prognosis in the face of a malformation diagnosed. LTP is mostly a decision of the pregnant woman herself and submitted to the 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 for autonomous decision regardless of the physician's opinion may be a root cause of moral distress (Prentice & Gillam, 2018). The Ministry of Health's position paper from 2007 (General Director’s note 19/12/1997- 23/2007 attempted to define more clearly the outline for LTP for reasons of fetal malformation or genetic disorder, stating that as the gestational age progresses, at least 30% probability for a significant handicap is needed to comply with the said restriction to justify a cessation of life at a gestational age in which the fetus is viable outside the womb. However, these guidelines cannot always help in the face of reality, 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, not only when the reason for seeking termination of pregnancy is fetal malformations but also when the reasons are the mother's mental or physical health, possible risk to her life, social causes, etc.

Another point that complicates the situation is the process of decision making that is unlike other decisions taken by a physician on a daily basis together with the patient. Typically, these professional decisions are based on formal medical knowledge, evidence-based medicine and the physician's professional experience. In LTP 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 (Prentice & Gillam, 2018). 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 (Dudzinski, 2016). A review of moral distress and its implications reveals that moral distress negatively affects clinician's well-being and job retention (Lamiani, Borghi & Argentero, 2017).

Feticide is not a private physician and patient's practice, but a procedure that is carried out within a department which is part of a hospital, and of the healthcare system under state regulations. As such the issues regarding it 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 reflect an environment where there has been insufficient ethical discussion that incorporates the views of all involved (Epstein & Hamric, 2009). Research (Legget, Wasson, Sinacore et al., 2013) show that there is 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. 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" (p.82) as Martin et al. (2017) call it, come with a personal and social cost to all involved. Opening up and reflecting on feticide can reinvigorate the discourse both of pro-choice and its moral meanings (Harris et al. ,2011). 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 the 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 maternal–fetal medicine. Still, more research is needed to further address the impact of interventional methods like training for the emotional aspects, access to support for work-related stress, ethics rounds, supervisions, and counselling.

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