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# How to deal with the criterion of severe mental distress for late termination of pregnancy? A scoping literature review and a content analysis of clinical ethics consultations

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## Abstract

**Background** The issue of late termination of pregnancy (abortion after a certain gestational age, depending on different definitions) is a topic of intense debate among healthcare professionals and the public, as it involves balancing the divergent interests and needs of the pregnant person and the foetus. Some jurisdictions recognize severe mental distress as a valid criterion for allowing late termination of pregnancy. However, the unavailability of a clear definition presents challenges in clinical practice.

**Methods** A scoping literature review was conducted to examine how the criterion of severe mental distress is operationalised in the context of late termination of pregnancy. In addition, we conducted a qualitative content analysis of clinical ethics consultation reports dealing with requests for late termination of pregnancy in a Swiss university hospital.

**Results** The scoping review of the literature yielded that 23 publications distributed worldwide were relevant to the question. Regarding the concept of severe mental distress, there is no uniform terminology. The indication for abortion is referred to as psychiatric, psychosocial, or sociomedical indication, or maternal emergency. Various criteria are mentioned that can contribute to categorising a condition as a severe mental crisis to varying degrees, including age, psychiatric illnesses, psychological conditions, foetal malformations, socio-economic conditions, or criminological circumstances. The qualitative content analysis of 20 clinical ethics consultation reports revealed a range of ethical challenges that arise in clinical practice, namely how the risk of severe mental distress can be assessed, whether the termination of pregnancy is suitable to avert the distress, and whether the termination of pregnancy is proportionate. We identified several recurring criteria that require clarification to aid decision making, such as whether treatment

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options and alternatives have been adequately discussed and presented, whether the request is consistent and enduring, and whether there are causes of severe mental distress that could be eliminated otherwise.

**Conclusions** For jurisdictions that allow late-term abortion based on severe mental distress, we propose a set of guiding questions to support healthcare professionals engaging in careful decision making.

**Keywords** Late termination of pregnancy, Late-term abortion, Severe mental distress, Mental disorder, Ethics, Autonomy, Clinical ethics consultation

## Introduction

After a certain gestational age (depending on different definitions, but usually at some point during the late first or early second trimester), a termination of pregnancy is called late-term [1]. If the pregnancy is far advanced and the foetus may be able to survive outside the pregnant person's body with medical assistance (expected after the 23rd week of gestation), feticide may be necessary [2].

In cases of late termination of pregnancy, the following ethical dilemma is intensified: on the one hand, the heath care team is primarily responsible for the health and well-being of the pregnant person and for preventing any harm coming to them, but on the other hand, moral considerations regarding the protection of the foetus become more prominent as the pregnancy progresses, particularly once viability has been reached [2, 3]. In the law, this is expressed by the fact that in many legal regulations, the more advanced the pregnancy is, the more protection is given to the foetus. In practice, various reasons can be cited for the request to terminate a pregnancy at a late stage, but in most cases, anomalies in foetal development detected by prenatal diagnostics play a crucial role. The obligations and diverging interests in the case of late termination of pregnancy are notoriously difficult to align.

## Legal and societal background

The concept of late termination of pregnancy is handled differently in several countries and various solutions are advocated to deal with the permissibility of late termination of pregnancy. The legal context for pregnancy termination varies greatly between legislations. Most Western European and some North American countries/states, e.g. Canada, California, or Oregon have a gestational limit with varying time limits, within which abortion is generally possible at the pregnant person's request, especially if the health of the pregnant person is at a risk or in case of severe fetal anomalies. But some countries do have very restrictive regulations in early pregnancy as well, such as Poland. Gestational age limits vary from 12 weeks or 90 days (Italy) to 18 weeks (Sweden) or the limit of viability (Netherlands). After these periods, in some countries, the criterion of severe mental distress is legally established for late termination of pregnancy, e.g., in all German-speaking countries in Europe.

As an example, the legislation of Switzerland includes averting severe mental distress as one criterion, whereby the risk alone is sufficient [4]. Termination of pregnancy is legally prohibited in Switzerland unless special conditions are met [5]. The protected legal interest of this provision is the developing human life during pregnancy, in principle regardless of its viability. According to the so-called time limit regulation, termination of pregnancy is justifiable if the pregnancy is terminated before twelve weeks from the last menstruation and the pregnant persons claim that they are in distress. After twelve weeks, termination of pregnancy is justifiable if there is a medical or psychosocial indication that must be confirmed by a physician [1]. The medical indication presupposes that a termination of pregnancy is suitable and can prevent imminent, serious physical harm to the pregnant person in a doctor's opinion. A psychosocial indication is affirmed if, without termination of pregnancy, the pregnant person could end up in an emotional emergency, i.e., in a *state of severe mental distress*. The physician must declare that severe mental distress to the pregnant person actually exists or will likely exist in the future [5]. Severe mental distress is not defined in more detail in Swiss law, and the legislature deliberately dispensed with a catalogue of criteria to be able to take account of the wide variety of life situations[1]. However, recognized subgroups have emerged in legal practice: the most important are "psychiatric" reasons in case of the pregnant person being mentally distressed, the "criminological" reasons when pregnancy is the result of a sexual offense, and "embryopathic" reasons [5]. The latter are usually present when the condition of the foetus is expected to result in such serious impairment after birth that the pregnant person and, if applicable, their family, consider the care to be an unreasonable burden. The individual circumstances of each case must always be considered. To consider the fact that termination of pregnancy is legally permissible until the onset of labour, the legislator has imposed special requirements on the examination of proportionality. The danger to the pregnant person must

[1] In Germany, for example, an explicit embryopathic indication for termination of pregnancy existed by law until 1995 but was removed due to its controversial nature, leaving only a "medical indication" focused on the physical or mental health of pregnant persons for abortions after 12 weeks past conception.

be greater the more advanced the pregnancy is. This allows for the gradually evolving status of the foetus during pregnancy to be considered.

### Research objectives

This article aims to examine the criterion of severe mental distress in the research literature and its application in the practice of a clinical ethics consultation (CEC) service to make ethically justified decisions on late-term abortions. The research questions are: [1] How is the concept of severe mental distress operationalized in the literature, i.e. what criteria are mentioned that a condition must fulfill to be considered severe mental distress [2]? What challenges can arise in using the concept in clinical decision-making in the context of CEC? This article does not address the question of whether an abortion should be legitimised in principle or when the beginning of life should be defined. Rather, it aims to present an overview of the concept of severe mental distress as identified in the literature and to examine its current use in the practice of CEC in a university hospital. Based on the conceptual and the practical analysis of this concept, the article will highlight the challenges of such a criterion and provide practical decision support in the form of guiding questions.

## Materials and methods

To answer the research questions, we conducted a scoping literature review and a qualitative content analysis of CEC reports.

### Scoping literature review

The scoping review follows the PRISMA extension for scoping reviews [6]. Publications were collected in January 2022 from three databases (PubMed, Scopus, Web of Science), and the search engine Google Scholar. These were selected on the basis that the topic relates to medical and ethical issues.

To construct the search code, the research question was structured in terms of two topics: termination of pregnancy and mental distress. Synonyms and main terms for these two fields were selected, and a search code was created for each database (including MeSH terms for PubMed). Since the criterion of mental distress is legally established in all German-speaking countries in Europe, a search code in German was created for Google Scholar to identify scientific literature as well as grey literature. To enhance the search code, full-text frequency analysis was used by Voyant Tools [12]. For details on the search code, see Full Search Code in the Supplementary materials. Further literature was obtained by the snowball method of reviewing the literature referenced in the included articles and by a citing reference search using the corresponding feature at Web of Science.

All identified references were collected and uploaded into Citavi (Lumivero: Denver, USA). After deduplication, one reviewer (JS) screened all titles and abstracts according to the inclusion criteria (for details, see Publication Selection Criteria in Supplementary Material). In the next stage of the screening process, the full texts of the selected references were screened independently by two reviewers (JS and MT). Reasons for exclusion of references were recorded. Publications in English, German, and French were considered. No restrictions were made on publication date or type.

An extraction form was developed by the reviewers for data extraction, including variables referring to bibliographic information (authors, title, year of publication, country), to the expressions used for severe mental distress, as well as to the general and specific criteria associated with this condition. The data were extracted by two researchers (JS and MT) independently. In cases of divergence regarding the criteria, the issue was resolved through renewed inspection and discussion where necessary, with a third author (ALW) serving as mediator.

### Qualitative content analysis of clinical ethics consultation (CEC) reports

Among the various approaches to ethics support, CEC is considered the most established approach with the greatest international recognition [7–9]. A CEC according to the Basel model [9–11] is chaired by an experienced clinical ethicist facilitating discussion in an interprofessional round (e.g., physicians, nursing staff, midwives, social workers, legal service, and clinical ethics' staff). It can be helpful and desirable that patients and relatives participate to have their first-hand perspective considered, but there may be reasons to forgo their participation, such as when the CEC is intended only as an exchange of health care professionals (HCP). For this reason, CECs on late-term abortions have so far taken place without the presence of patients. All staff members, patients, or their relatives can request a CEC. However, the request for a CEC on late-term abortion has so far always been made by a physician but other disciplines, such as nurses, midwives, and legal or social services, participated in the CEC. All those HCP involved who had prior contact with the pregnant person report their experiences with them. In particular, it is the head of the division of gynaecological psychosocial medicine who conduct the interviews with the pregnant person in advance. Even though the decision about granting a request for termination of pregnancy ultimately rests solely with the attending physician, the CEC is used to hear the perspectives of everyone on the health care team and to include them in the decision-making process.

Of each CEC, structured minutes are taken by a member of the Clinical Ethics Unit. The structured document

is used for the report and covers three to ten pages. In addition to the ethical focus and information on the patient, this includes the various perspectives of the parties involved (patient, relatives, health care team, other institutions), information on applicable law, the various options for action, and a result on an ethically justifiable procedure (for details on the structured document, see "Structured document of CEC report based on the Basel model" in the Supplementary materials). The participants can comment and suggest changes to the report before it is finalized. The ethical analysis in the CEC is guided by the four-principles approach of Beauchamp and Childress, an internationally recognized approach in medical ethics that considers respect for autonomy, non-maleficence, beneficence, and justice [13]. The CEC aims to find a consensual procedure; there are explicitly no binding recommendations for action on the part of the Clinical Ethics Unit and there is no mandatory follow-up regarding the implementation of the results. In terms of content, the CEC is concerned with providing the clinical team with a space and process to develop an ethically defensible care plan within the applicable law. Political activism or a judgment on the ethical defensibility of the given regulations find less room within the framework of the CEC. There is no obligation for the HCP to request an CEC before a late-term abortion is carried out; therefore, we cannot say how many requests for late-term abortions took place in the reviewed period and what the ratio of the various reasons (medical or mental distress, see Table 2) in gynaecological practice is.

Based on the research question which ethical challenges clinicians, patients, and ethicists face in practice concerning late termination of pregnancy, qualitative content analysis based on Mayring [14] was performed. Therefore, all CEC reports in a Swiss University Hospital between 2012 and 2021 were searched for those dealing with requests for late termination of pregnancy. The documentation of the resulting final sample of cases served as the basis for the research material. The defined existing categories of the protocols were summarized into inductive categories in which the content of the categories was based on what information from the protocols could provide insight into the research question. The following pre-defined variables were used: gestation week, pregnant woman's age, legally required indication for late termination of pregnancy (with the subcategory in the case of mental distress, whether there was an embryopathy present or not), person's reasons for their request, ethical considerations of HCP, and decision including main considerations. For the coding process, the individual sections from the CEC protocols were assigned to categories by identifying information about the request for an abortion, for example an embryopathy; or the pro and con arguments, mentioned in the CEC protocols, were used for the ethical consideration; or from the conclusion whether a termination took place or not and what the main considerations for the decision were.

The coding system was established, and the structuring content analysis performed independently of each other by two authors (CW and LW) to ensure as much transparency and neutrality as possible.

## Results

### Scoping literature review

The results of the literature search are shown in the PRISMA flowchart (see Fig. 1).

Of the 23 publications, 14 were from Europe (Switzerland, Italy, Germany, France, UK), five were from North America (Canada, USA), three were from Australia or New Zealand, and one was from Asia (Malaysia). For further characteristics of the publications, see Table 1.

Regarding the term «severe mental distress», there is no uniform terminology. Most publications refer to the risk or actual condition of (severe) emotional, psychological, or mental distress or the risk of impairment, damage, or injury to the mental health of the pregnant person by continuing the pregnancy. The indication for termination of pregnancy due to severe mental distress is also referred to in different ways: as a psychiatric, psychosocial, socio-medical, maternal emergency, or mental health indication. Some authors dispense with the term «indication» altogether and instead speak only of therapeutic or psychological or psychosocial reasons for termination of pregnancy [21, 24, 25]. Only Riquin et al. [15] provide a general description of the term «psychosocial suffering», as suffering that is both «subject to a more or less elaborated mental process» and based on the «feeling of acceptance or exclusion from [a social] group».

Several general criteria for the risk or actual condition of severe mental distress are cited: psychiatric, psychological, embryopathic, socioeconomic, or criminological. The psychiatric criterion is mentioned by almost all authors; Cook et al. [16] distinguish between (i) a major suicide risk and/or aggressive acts towards the foetus, (ii) a current serious and/or chronic mental illness that is aggravated by the pregnancy (iii) or a risk posed to the future mental health of the woman if the pregnancy is continued. Examples mentioned for current or chronic mental illnesses are mental disorders associated with pregnancy, depressive disorders, schizophrenia or other psychotic disorders, anxiety disorders, substance use disorders, personality disorders, eating disorders, or neurodevelopmental disorders.

The psychological criterion includes psychological states that are due to pregnancy but do not meet diagnostic criteria for a mental disorder. Examples given are emotional turmoil related to an unwanted pregnancy, denial of pregnancy, fear of childbirth, a feeling of

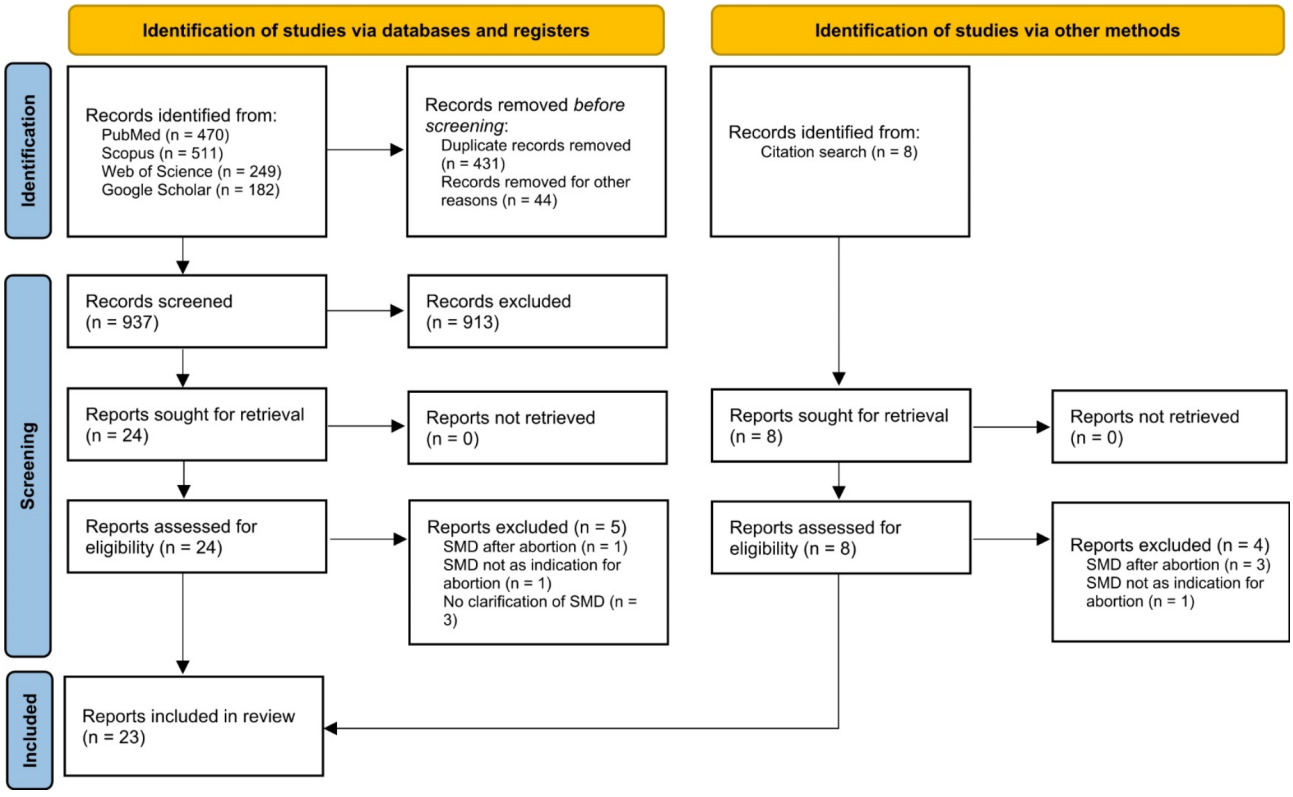


**Fig. 1** PRISMA flowchart

immaturity regarding parenthood, a feeling that one will not be a good parent, or a prolonged state of exhaustion (15, 16, 21, 25, 26, 30, 31, 38).

From the psychological criterion, the embryopathic and socioeconomic criteria can be distinguished. The first includes the psychological states of the pregnant person that are specific to a diagnosis of severe physical or mental impairment of the foetus. Such conditions may be an overburdening of the pregnant person to care for a child with such an impairment or an overburdening resulting from the fact that the parents or close family members are themselves severely affected by this impairment. It may also be a desire to spare the child suffering, such as when the child is expected to die quickly after birth. Various examples of foetal conditions mentioned in this context include anencephaly, thanatophoric dwarfism, trisomy 13 or 18, holoprosencephaly, triploidy, or hydranencephaly (4, 27, 29, 30, 31, 37).

The socioeconomic criterion includes the mental conditions of the pregnant persons that can be attributed to their social and/or economic circumstances. These are, for example, existing or expected problems in the partnership, lack of family or social support, existing social obligations, social pressure or repression, risk of family violence against the parents, social isolation or marginalization, financial problems, loss of job or threat to education, career, or marriage [15, 16, 21–25, 30, 31, 36–38, 40].

The criminological criterion is met if the pregnancy results from sexual violence such as rape, sexual assault, or defilement or – depending on the law – from sexual intercourse between close family members [16, 22, 24, 31, 32, 36].

### Qualitative content analysis of CEC reports

There were 206 CEC in total during 2012 and 2021, and 20 of these dealt with the question of late termination of pregnancy. Pregnant persons with a request for late termination of pregnancy ranged in age from 15 to 41 years. They were at 15 to 31 weeks of gestation. Seventeen of the 20 CEC were inquired about a possible termination of pregnancy after the 16th week of gestation. One of the 17 cases was at the 24th week of gestation, and two were at or after the 30th week.

Of the 20 CEC with the question of late termination of pregnancy, two were related to averting a risk of serious physical harm to the pregnant person ("medical" criterion in Table 2). In both cases, the CEC concluded that a termination of pregnancy would be legally and ethically justifiable. In contrast, 18 cases involved the issue of severe mental distress for late termination of pregnancy. Two-thirds of these 18 cases ($n = 12$) were based

on embryopathic reasons as a primary trigger for mental distress, and one-third ($n = 6$) on other reasons like psychiatric, psychological, or social difficulties. Whether a social, psychiatric, or psychological aspect or, if present, also an embryopathy was ultimately decisive for the mental distress cannot always be inferred from the reports.

Reasons given by the pregnant person for termination of pregnancy included fear of social ostracism, impending financial hardship, serious family or partnership conflicts and possible disabilities of the child, or fear of excessive demands due to the child's limitations.

In CEC the question arose as to whether the difficult situation for the pregnant person is so serious that it could be considered as severe mental distress that ultimately justifies an abortion. For ethical considerations, the legislature provides the framework within an ethical analysis and consideration of the individual case by the HCP takes place. A significant part of the ethical considerations concerned the question of whether the balancing of ethical principles leads to legal admissibility or not. HCP ethical concerns related to the questions of whether the pregnant person had already been adequately informed about the various options (treatment options, adoption, financial and social support options, etc.). Since the CEC was always convened as early as possible so as not to waste time, it was possible that necessary discussions with the pregnant person and the specialists had not yet taken place. HCP ethical concerns related also to whether the distress was severe enough for a termination of pregnancy to be considered proportionate, or whether termination of pregnancy was the appropriate intervention to avert the risk of severe mental distress. Additionally, their concerns were directed at the possible performance of the termination of pregnancy itself, especially if the foetus could be viable, and therefore feticides were required. When embryopathies were brought up as triggers for the wish for a late termination of pregnancy, it was difficult not only to explore whether treatment options were available and whether the embryopathy was severe enough to justify a termination of pregnancy but also to focus on what distress the embryopathy caused individually in the pregnant person and thus served as a justification. It was also difficult to assess whether the distress was great enough in relation to the stage of pregnancy as required by Swiss law. If the diseases were treatable, it was even more challenging to understand the severity of the mental distress because the reason for the mental distress can be dealt with, and the mental distress could thus be possibly resolved without the termination of the pregnancy.

The result of these 18 CEC (see Table 2) was in three cases that a late termination of pregnancy was legally and ethically indefensible, and in two cases that it was justifiable. In thirteen cases, the wish for an abortion was generally understandable for the HCP involved, but further steps were needed to conclude whether they considered late termination of pregnancy as legally and ethically justified. The reasons were that further information was needed on the severity of the pregnant persons' severe mental distress or because they were not yet considered to be sufficiently informed. Open questions of the CEC could be identified, such as whether the pregnant person was already adequately informed, whether alternatives were adequately discussed, whether social services or spiritual care were involved, or whether the pregnant person's wish was constant.

## Discussion

According to our scoping review, there is no established definition of "severe mental distress" in the context of late-term abortion, nor are there established, operational criteria for determining when a condition meets the criteria for severe mental distress. This lack of conceptual clarity adds to the challenge of making an ethically appropriate decision in each individual case. In addition to this difficulty in assessing (the risk of) severe mental distress, four other challenges to ethical decision-making can be identified based on the CEC reviewed: (1) timing of CEC, (2) non-participation of the pregnant person, (3) assessment of the (risk of) severe mental distress, and (4) proportionality.

### Challenges regarding the assessment of (the risk of) severe mental distress

#### *Timing of CEC*

One challenge observed in the CEC was the fact that the pregnant person had not yet sufficiently processed the complex situation and the counselling and support offered, or that the necessary discussions had not yet taken place. This was not necessarily because the critical clarifications had been neglected by the health care team in advance, but rather because the CEC – to support the team in the decision-making process, not to make the decision – was convened as early as possible to undertake a joint reflection on how to deal with the patient's request, especially given the existing time pressure. The major aspect seems that the supervising team convenes the CEC when it comes to a point where reflection becomes necessary. The CEC's task is not to make the decision but to support the team in the decision-making process. Multiple meetings might be needed to allow for comprehensive reflection after more information exists or is given to the pregnant person (which was not the case in the CEC examined); this in turn would represent a loss of time that could further complicate the issue of the permissibility of a late termination of pregnancy. In case CEC is convened at an early stage, the task can therefore also be to critically question what information still needs

to be obtained or what clarifications are still required to be able to assess the existence of a risk of severe mental distress and to make an ethical evaluation. As a profession not involved in the treatment, the ethics consultant can contribute to examine whether the previous considerations are comprehensible from the outside. By introducing and weighting the four ethical principles, the experiences and thoughts of the HCP can be explained and justified in an objective and understandable way. A checklist of the open questions identified in the CEC and especially based on the authors` analysis of the CEC protocols, is provided in Table 3.

#### *Non-participation of the pregnant person*

Another challenge is the question of the constellation in which the CEC should take place. The absence of the patient has the disadvantage that their perspective is only indirectly brought in, and the pregnant person cannot speak for themself. The HCP who all had discussions with the patient must bring the information about the risk of mental distress to the panel. The reporting person's assessments of the patient's subjective feelings must be substantiated to the extent that the aspects used are comprehensible to outsiders. Conveying the interpersonal feelings that occurred during the physician-pregnant person interview, possibly also non-verbal expressions, can be challenging. One way to address this disadvantage is to have the pregnant person attend the discussion. The pregnant person seeking termination of pregnancy is in a particularly vulnerable situation. Participating in the discussion may be too much of a burden, which may prevent HCP from speaking openly. This dilemma could be resolved with a two-stage process in which the pregnant person is offered to join the CEC in a second stage [17]. Persons may also be offered the opportunity to speak directly with a clinical ethics consultant before and/or after the CEC [18]. In any case, we recommend that a clear procedure for patient involvement is established and that the reasons for including or excluding the pregnant person from the CEC are considered on a case-by-case basis [36].

#### *Assessment of (the risk of) severe mental distress*

To approach the meaning of this criterion, it is necessary to focus on determining whether the circumstances presented by the pregnant person individually led to a risk of severe mental distress that must be averted. The understanding of the concept of severe mental distress plays a significant role. It can be understood as an intrapsychic state of suffering, which can be characterized by psychological complaints, or as a generally emotionally stressful life situation, which can be characterized by objectifiable contextual factors. In clinical practice in ethics consultations on late termination of pregnancy, both conceptualizations of mental distress often play a role and are complementary to each other [19]. Thereby a reflex to focus only on an objective circumstance (e.g., an embryopathy) should be avoided but may be related to the fact that it is easier to base a decision on concrete criteria, or to the fact that it may be unfair to attribute the reason for termination of pregnancy solely to the pregnant person as the one who is «unable» to continue the pregnancy - even if embryopathy may justify termination of pregnancy to spare the child suffering. Conversely, difficulties may arise, when a well-treatable disease of the child (e.g., a cleft lip and palate) makes it challenging to accept a «severe» mental distress of the pregnant person. And even if embryopathy itself is not supposed to be a legitimate reason for abortion, studies show that both pregnant person and professionals negotiate severity behind the scenes. Thereby the interpretation of severity is highly context-dependent and relies on clinical, social and familial facets [20]. In such cases, it is particularly difficult to examine and evaluate the subjective feeling of the pregnant person, namely their personal, individual risk of becoming distressed. The question of whether the pregnant person succeeds in demonstrating the plausibility of the risk of severe mental distress can depend heavily on the moral attitude of the practitioners and those involved in the CEC. An interdisciplinary CEC can help to identify and reflect participants individuals' biases. As the task in CEC is to assess the subjective severity, it may be necessary to obtain additional expertise from a mental health expert or to include the findings of such a person already involved in the further decision-making process.

#### *Proportionality*

Another challenge in the CEC is the (legal) required proportionality: An incremental concept of the moral status of the human foetus that underpins legal norms on termination of pregnancy in many countries seems to imply that the risk of severe mental distress must be proportionate to the stage of pregnancy [2]. In addition, if the pregnancy is far advanced, feticide may be necessary, which places an additional burden on those involved.

This brings up the question of whether it can be ethically justifiable to refuse a request for late termination of pregnancy despite the presence or risk of severe mental distress in the pregnant person because the foetus would already be viable. The law in Switzerland at least allows this but what role, if any, should personal conscientious objection play?

For the ethical consideration, the protection of the viable foetus plays a role on the one hand, and the rights of the pregnant person on the other. The more advanced the pregnancy, the more severe the pregnant person's mental distress must be, as the law requires in the interests of proportionality. It must not be forgotten that not only

does the pregnant persons autonomy play a role here, but the priority is to avoid severe mental distress, i.e., to prevent harm to the pregnant person (ethical principle of beneficence). Discussion of possible alternatives, such as adoption, could possibly balance the rights of both parties and be a solution.

### Recommendations for the decision-making process

The above-mentioned challenges raise the following questions regarding the ethical justification of a request for late termination of pregnancy:

1. How can severe mental distress be assessed, or its risk determined?
2. Is termination of pregnancy an appropriate measure to avert (the risk of) severe mental distress?
3. Is termination of pregnancy proportionate? Is the risk great enough, given the advanced stage of the pregnancy, to justify an abortion?

Any attempt to answer these questions, in the absence of clearly defined standards, harbours the risk of arbitrariness. The inexistence of clearly defined criteria causes uncertainty among the HCP. To assist in the decision-making process and address these challenges, a catalogue of recurring guiding questions may be helpful. This catalogue provides practical assistance in fulfilling the duty of care, including a CEC if available. It is recommended that the checklist be processed as early as possible (see Table 3).

## Conclusion

The criterion of severe mental distress is present in many jurisdictions. Its operationalization in clinical decision making is complex and raises several ethical challenges. So far, there is little guidance or systematic training for HCP on how to deal with these challenges. CEC can play an advisory role and help clarify criteria, structure decision-making processes, and work toward, consistent, well-justified decisions. This task is delicate and complex due to the potential for moral distress and conflict among the care team and between providers and the pregnant person. Guiding questions can support the process, especially when a clinical ethics service is not available.

### Abbreviations

| | |
|---|---|
| CEC | Clinical ethics consultation |
| HCP | Health care professionals |
| MeSH | Medical subject headings |
| UK | United Kingdom |
| USA | United States |

## Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12910-025-01207-3.

Supplementary Material 1

### Author contributions

CW, JS, LW, and MT designed the study. CW, JS, LW, ALW, MT, and ST were involved in data analysis. All authors were involved in the discussion of the ethical aspects of the cases at hand. CW, JS, and MT drafted the manuscript. All authors provided feedback on the early versions of the manuscript. CW, JS, NBA, ST, GMB, and MT revised the manuscript substantially. All authors agreed upon the final version of the manuscript.

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### Data availability

No datasets were generated or analysed during the current study.

## Declarations

### Ethics approval and consent to participate

The study was exempted from review by the Ethics Committee for Northwest and Central Switzerland (EKNZ) because the evaluation of the anonymized CEC minutes is not defined as research on diseases or the structure of the body according to HFG Art. 2, Abs. 1 (EKNZ; Req-2021-00301).

### Consent for publication

Not applicable.

### Competing interests

The authors declare no competing interests.

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