



Title	Selective foeticide in Hong Kong: lawful or not?
Author(s)	Leung, KY; Lau, WL; Law, KM
Citation	香港醫學雜誌, 2001, v. 7 n. 4, p. 429-431
Issued Date	2001
URL	http://hdl.handle.net/10722/146331
Rights	Creative Commons: Attribution 3.0 Hong Kong License

KY Leung 梁國賢
 WL Lau 劉偉霖
 KM Law 羅國明

Selective foeticide in Hong Kong—lawful or not?

香港的選擇性墮胎——合法與否？

.....
 There is legal uncertainty as to whether selective foeticide is authorised under section 47A of the Offences Against the Person Ordinance (1967). Medical and legal issues surrounding a case of selective foeticide in a triplet pregnancy are reported.

依照1967年通過的對人體犯罪條例第47A節，選擇性墮胎合法與否並沒有確定的法律依據。本文報告了一個關於三胞胎的選擇性墮胎案例的醫學和法律事務。

Introduction

When a multiple pregnancy is complicated by a single anomalous foetus, the problem is not restricted to the anomalous foetus. The outcome of the other foetuses will also be adversely affected.¹ The management of this complicated multiple pregnancy is difficult. Selective foeticide of the anomalous foetus is one of the management options.²

English law has been amended to address the issue of selective foeticide.³ In Hong Kong, the Human Reproductive Technology Ordinance was enacted on 29 June 2000. This Ordinance provides, inter alia, for the selective reduction of multiple pregnancies. Until the new law comes into effect, whether selective foeticide is authorised under section 47A of the Offences Against the Person Ordinance (1967) or whether a court declaration is required remains an issue.

We report a triplet pregnancy in which selective foeticide of a foetus with an encephalocele was undertaken. The legal grounds for selective foeticide are discussed.

Case report

A 34-year-old woman was treated as a result of primary infertility due to male factor infertility. She conceived a triplet pregnancy after receiving ovulation induction and intrauterine insemination. An ultrasound scan at 12 weeks' gestation showed an encephalocele (3.2 x 6.6 x 5.5 mm³) in one foetus. There was a fused placenta with a chorionic peak sign and thick septae compatible with trichorionic triamniotic triplets. The encephalocele was confirmed on repeated ultrasound examination and measured 12 x 15 x 16 mm³ at 15 weeks of gestation.

The couple was counselled and opted for selective foeticide. They were aware that it would be the first time a foetal intracardiac injection had been used in a triplet pregnancy at Queen Elizabeth Hospital. The operator's level of experience in invasive procedures was explained.

Key words:

Abortion, legal;
 Ethics, medical;
 Pregnancy, multiple;
 Pregnancy reduction, multifetal;
 Triplets

關鍵詞：

流產，合法的；
 道德，醫學的；
 懷孕，多胎的；
 懷孕減少，多胎的；
 三胞胎

HKMJ 2001;7:429-31

Department of Obstetrics and Gynaecology,
 The University of Hong Kong, Queen Mary
 Hospital, 102 Pokfulam Road, Hong Kong
 KY Leung, MRCOG, FHKAM (Obstetrics and
 Gynaecology)

Department of Obstetrics and Gynaecology,
 Kwong Wah Hospital, 25 Waterloo Road,
 Kowloon, Hong Kong

WL Lau, MRCOG, FHKAM (Obstetrics and
 Gynaecology)

Department of Obstetrics and Gynaecology,
 Queen Elizabeth Hospital, 30 Gascoigne
 Road, Hong Kong

KM Law, MRCOG, FHKAM (Obstetrics and
 Gynaecology)

Correspondence to: Dr KY Leung

As there is uncertainty in the interpretation of section 47A, legal advice was sought. Legal advice indicated that although a definitive ruling required a court order, it was not unreasonable to apply section 47A to terminate the deformed foetus of the triplet pregnancy, provided that the conditions in section 47A were satisfied.

Selective foeticide was performed at 16 weeks' gestation by transamniotic injection of 1 mL (equivalent to 2 mmol) potassium chloride into the heart of the abnormal foetus, identified by the presence of an encephalocele. The procedure was without complications. Amniocentesis of the two remaining foetuses was not performed.

Subsequent ultrasound scans showed that the other two foetuses were structurally normal, without features of embolism. The sac around the dead foetus had collapsed. Mild polyhydramnios (amniotic fluid index 22.8) was detected at 22 weeks of gestation, however. An oral glucose tolerance test (75 g) was performed due to the polyhydramnios, and the result was abnormal. The patient's fasting and 2-hour serum glucose levels were 6.1 mmol/L and 12.8 mmol/L, respectively. Treatment involved a 1800 Kcal diabetic diet and subsequently, blood glucose levels returned to normal.

The patient received weekly dexamethasone injections from week 28 of the pregnancy, and was hospitalised for rest from week 29. Her clotting profile remained normal. The polyhydramnios resolved spontaneously at week 31. Ultrasound showed that the dead foetus was in the left cornual region. Serial ultrasound and Doppler studies showed normal interval growth of the two surviving foetuses. The estimated foetal weights at 31 weeks of gestation were 1528 g and 1759 g for triplet 1 and triplet 2, respectively.

Premature rupture of the membranes occurred at 33 weeks of gestation, however. The liquor around triplet 1 was diminished, while the liquor around triplet 2 was normal. An emergency lower segment caesarean section was performed under regional anaesthesia because of multiple pregnancy, preterm premature rupture of membranes, and infertility. Triplet 1 was a boy, weighing 1.58 kg, with an Apgar score of 7 at 1 minute and 9 at 5 minutes. Triplet 2 was also a boy, weighing 1.74 kg, with an Apgar score of 9 at 1 minute and 9 at 5 minutes. Triplet 3 was a small abortus. The operation and postpartum course were uneventful. There were no major neonatal morbidities. The two surviving babies were discharged 3 weeks after birth.

The pathology report showed a trichorionic triamniotic placenta without features of inflammation. The abortus was macerated and the size corresponded to 14 to 15 weeks of gestation. There was a 1 cm skin bulge over the occipital region of the foetal skull, suggestive of an encephalocele.

The patient was well on postnatal follow-up and free from depressive symptoms. Her oral glucose tolerance test at this time was normal, and the two babies were healthy.

Discussion

Section 47A does not specify whether it refers to a singleton or multiple pregnancy. According to legal opinion, one can argue that if one of the foetuses is terminated, the pregnancy is not terminated but continues. The counter-argument is that since that pregnancy is a multiple pregnancy, it may be viewed as involving more than one pregnancy, particularly since the focus on the abortion law is on the life of the individual foetus and not on the condition of pregnancy as such.

The legal advice given in this case was based on section 47A and the judgement of Justice Cheung on a case of selective foeticide.⁴ In that case, Justice Cheung ruled that aborting one foetus in a twin pregnancy was lawful. Justice Cheung made reference to the uncertainty regarding the legal position of terminating one of the foetuses in a multiple pregnancy and his decision in this case could have been only on the basis that section 47A authorised the termination of one foetus in a multiple pregnancy, if other conditions under the section were satisfied.

The conditions in section 47A were satisfied in the current case. Two doctors were of the medical opinion that if the foetus with an encephalocele was born, there was a substantial risk of physical or mental abnormality, leading to serious handicap. The risk of mortality and neurological deficit was estimated to be 23% and 39%, respectively.⁵ Besides this justification, the duration of pregnancy at that time was less than 24 weeks.

The other medical grounds for terminating the abnormal foetus would be to provide a better intra-uterine environment for the remaining two foetuses.⁶ The legal advisor, however, commented that this medical consideration was not a relevant legal ground for selective foeticide under section 47A. Relevant legal grounds are based on consideration of the

mother or the abnormal foetus only. Given this legal consideration, it is questionable whether the conditions in section 47A would be satisfied in the other two commonly quoted medical indications for selective foeticide—multifoetal reduction and twin-twin transfusion. In multifoetal reduction, the consideration is not a severely abnormal foetus. According to the proposal from the Draft Code of Practice on Reproductive Technology and Embryo Research, multifoetal pregnancy reduction should not be carried out unless it is authorised by the court.⁷ In twin-twin transfusion, medical grounds for terminating the life of a donor twin are to improve the survival of the recipient twin.⁸ Whether the donor twin will suffer from severe physical or mental handicap after birth is arguable since the donor twin is usually in preterminal condition before selective foeticide is considered.⁸ In addition, the twin pregnancy may be of more than 24 weeks of gestation at the time of presentation.

Conclusion

Prior to amendment of the abortion law in Hong Kong, there remains uncertainty as to whether section 47A of the Offences Against the Person Ordinance (1967) allows for selective foeticide in a multiple pregnancy. It should be noted that medical grounds are not

equivalent to legal grounds for selective foeticide. It would appear that section 47A covers selective foeticide for a severe foetal anomaly before 24 weeks of gestation, provided the conditions outlined in section 47A are satisfied.

References

1. Albrecht JL, Tomich PG. The maternal and neonatal outcome of triplet gestations. *Am J Obstet Gynecol* 1996;174: 1551-6.
2. Malone FD, D'Alton ME. Management of multiple gestations complicated by a single anomalous fetus. *Curr Opin Obstet Gynecol* 1997;9:213-6.
3. Human Fertilisation and Embryology Act 1977, s 37.
4. Hospital Authority and others vs Secretary for Justice, 24 December 1997, Justice Cheung, HCMP 4493.
5. Docherty JG, Daly JC, Carachi R. Encephaloceles: a review 1971-1990. *Eur J Pediatr Surg* 1991;1(Suppl 1):11S-13S.
6. Yaron Y, Bryant-Greenwood PK, Dave N, et al. Multifetal pregnancy reductions of triplets to twins: comparison with nonreduced triplets and twins. *Am J Obstet Gynecol* 1999; 180:1268-71.
7. Provisional Council on Reproductive Technology. Draft Code of Practice on Reproductive Technology and Embryo Research. Hong Kong: Hong Kong Provisional Council on Reproductive Technology; 1999 Feb. Sect.8.8.
8. Duncan KR, Denbow ML, Fisk NM. The aetiology and management of twin-twin transfusion syndrome. *Prenat Diagn* 1997;17:1227-36.