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Committee on Ethics

This Committee Opinion was developed by the Committee on Ethics of the American College of Obstetricians and Gynecologists as a service to its members and other practicing clinicians. Although this document reflects the current viewpoint of the College, it is not intended to dictate an exclusive course of action in all cases. This Committee Opinion was approved by the Committee on Ethics and the Executive Board of the American College of Obstetricians and Gynecologists.

Multifetal Pregnancy Reduction

ABSTRACT: Fertility treatments have contributed significantly to the increase in multifetal pregnancies. The first approach to the problem of multifetal pregnancies should be prevention, and strategies to limit multifetal pregnancies, especially high-order multifetal pregnancies, should be practiced by all physicians who treat women for infertility. Incorporating the ethical frameworks presented in this Committee Opinion will help physicians counsel and guide patients when making decisions regarding multifetal pregnancy reduction. In cases of high-order multifetal pregnancies, counseling should include the availability of multifetal pregnancy reduction. Fellows should be knowledgeable about the medical risks of multifetal pregnancy, the possible medical benefits of multifetal pregnancy reduction, and the complex ethical issues inherent in decisions regarding the use of multifetal pregnancy reduction. Physicians should not be required to act in ways that conflict with their value systems but should be prepared to react in a professional and ethical manner to patient requests for both information and intervention.

The purpose of this Committee Opinion is to review the ethical issues involved in multifetal pregnancy reduction. These are highly complex, and no one position reflects the variety of opinions within the membership of the American College of Obstetricians and Gynecologists (the College). For the purpose of this document, *multifetal pregnancy reduction* is defined as a first-trimester or early second-trimester procedure for reducing by one or more the total number of fetuses in a multifetal pregnancy (1). In many cases, the involved gestations will be "high-order" multifetal pregnancies, defined by the presence of three or more fetuses.

In this opinion, the College's Committee on Ethics presents the ethical principles that play a role in decisions regarding multifetal pregnancy reduction. In addition, it provides an ethical framework that can be used by physicians in counseling patients regarding multifetal pregnancy reduction. Based on these principles and the framework, the Committee on Ethics offers the following recommendations:

- Fertility treatments have contributed significantly to the increase in multifetal pregnancies. Strategies to limit multifetal pregnancies, especially high-order multifetal pregnancies, should be practiced by all physicians who treat women for infertility.
- Fellows should be aware that multifetal pregnancies increase both maternal and neonatal morbidity and mortality. High-order multifetal pregnancies present higher risks than do twin pregnancies.
- Fellows should be knowledgeable about the medical risks of multifetal pregnancy, the possible medical benefits of multifetal pregnancy reduction, and the complex ethical issues inherent in decisions regarding the use of multifetal pregnancy reduction. They should be prepared to react in a professional and ethical manner to patient requests for both information and intervention.
- Counseling should be provided to women with high-order multifetal pregnancies. Resources for providing such counseling include perinatologists, neonatologists, mental health professionals, child development specialists, support groups, and clinicians with expertise in multifetal pregnancy reduction.
- Respect for autonomy is the principle that argues that it is the patient who must balance the relative importance of the medical, ethical, religious, and

socioeconomic determinants and pursue the best course of action for her unique situation.

- In many cases, a consultation to discuss the care of a multifetal pregnancy or the risks and benefits of reducing a multifetal pregnancy is warranted. When referring the patient for consultation, the referring practitioner should do so in a timely fashion, explain to the patient the reason for the consultation, provide all necessary information to the consultant, and maintain continuity of care.

Incidence and Risks of Multifetal Pregnancies

Spontaneous multifetal pregnancies have always posed increased medical risks to pregnant women and their fetuses. Over the past several decades, the increased use of assisted reproductive technology (ART) has led to a dramatic increase in the incidence of multifetal births. Between 1980 and 2009, the twin rate increased 76%, from 18.9 to 33.3 per 1,000 live births (2). The triplet or greater birth rate increased more than 400% between 1980 and 1998, when it peaked at 1.935 per 1,000 births (3). Between 1998 and 2009, the incidence of high-order multiple deliveries decreased by 29% (3). This decrease is the result of both a reduction in the number of embryos transferred with each cycle of in vitro fertilization (IVF) and an increase in the number of multifetal pregnancy reduction procedures being performed.

The specific ART techniques that have had the most profound effect on the increase of multifetal pregnancies are IVF and controlled ovarian hyperstimulation with gonadotropins. According to the most recent data available from cycles completed in 2010, 26% of pregnancies after IVF are twin pregnancies and 1.3% are high-order multifetal pregnancies (4). Advances in science have allowed physicians to better select embryos with a good chance of implanting; this has allowed clinicians to limit the number of embryos transferred into a woman's uterus during an IVF cycle. Although these advances have reduced the rate of high-order multifetal pregnancies after IVF (from 6% as recently as 2003 to 1.3% in 2010), the risk remains higher than with naturally conceived pregnancies. For example, a woman undergoing IVF has an approximate 22-fold increased risk of conceiving a twin pregnancy and a 100-fold increased risk of conceiving a triplet pregnancy, as compared with natural conception (4). In cycles involving controlled ovarian hyperstimulation with gonadotropins, the risk of a high-order multifetal pregnancy is significantly higher than with IVF. It is estimated at 9% (5).

Although not all multifetal pregnancies occur after the use of ART, fertility treatments have contributed significantly to the increase in multifetal pregnancies. Strategies to limit multifetal pregnancies, especially high-order multifetal pregnancies, should be practiced by all physicians who treat women for infertility. These strategies include canceling an ovulation induction cycle that is at high risk of resulting in a multiple gestation and limiting the number of embryos transferred during IVF.

Infants born as part of a multiple pregnancy are at increased risk of prematurity, cerebral palsy, learning disabilities, slow language development, behavioral difficulties, chronic lung disease, developmental delay, and death (6–8). The risks of perinatal as well as maternal morbidity and mortality increase with the presence of each additional fetus. Despite technologic advancements in neonatology, there has been no reduction in mortality for infants born at the border of viability over the past decade (9). The risk of spontaneous loss of the entire pregnancy is 25% for quadruplets, 15% for triplets, and 8% for twins (10). The relative risk of cerebral palsy in twins and triplets compared with singletons is 4.9 and 12.7, respectively (11). The risk of death by age 1 year is seven times higher in twins and 20 times higher in triplets, as compared with singletons (7).

Maternal risks of multifetal pregnancies include hypertension, preeclampsia, gestational diabetes, and postpartum hemorrhage (12). There also are significant economic adverse effects of multiple pregnancies, such as the need for additional child care, greater household and medical expenditures, and the possibility that one of the parents will be unable to return to the workforce (13). There also are significant medical costs associated with multiple gestations. As compared with singletons, estimated health care expenditures are quadrupled for twins and are 10 times higher for triplets (14). Multiple births are associated with an increased risk of severe parenting stress and a reported compromise in quality of life (15, 16). There also is an increased risk of maternal depression and child abuse in families raising multiples, particularly when one or more of the children has special needs (17). The rates of divorce among parents of multiples may be increased (13, 18, 19).

Ethical Considerations

The principles of medical ethics illustrate the complexities involved in decisions surrounding continuing or reducing a multifetal pregnancy. These principles may provide an ethical guide for physicians when counseling patients who conceive a multifetal pregnancy. Physicians should be aware that these principles serve only as a guide to navigating this complex decision-making process. They do not provide absolute answers as to the "right" course of action. Moral, religious, social, cultural, and economic factors all play a role in how these ethical principles are understood by a given woman and affect the weight each of these principles will have on her unique decision-making process. There are many ways in which individuals may frame ethical issues. These include utilitarianism, duty-based ethics (20), and feminist ethics (21). A more detailed discussion of the role of ethical principles and other ethical perspectives in decision making may be found elsewhere (22).

Respect for Autonomy

In the context of reproduction, respect for autonomy is represented by respect for a woman's reproductive liberty. Respect for autonomy acknowledges a woman's right to hold views, make choices, and take actions based on her personal values and beliefs. In order for a woman to make appropriate choices, she must be given adequate information about her diagnosis, prognosis, and alternative treatment choices, including the option of no treatment. This provides the foundation for informed consent, which is central to the principle of respect for autonomy (23). Respect for autonomy does not lead to decisions for or against multifetal pregnancy reduction, but rather allows each woman to reach, free of coercion, the conclusion that is best in alignment with her set of values and beliefs.

Respect for the physician's autonomy also is important in multifetal pregnancy reduction decisions. Physicians should not be required to act in ways that conflict with their value systems. In cases in which a patient desires a multifetal pregnancy reduction that a physician is not comfortable performing, timely referral to a physician expert in counseling and performing multifetal pregnancy reductions should be provided (24). Conversely, situations may arise in which a woman decides against multifetal pregnancy reduction when the physician feels strongly that a reduction is the best course of action, and she, too, should be appropriately referred.

Beneficence and Nonmaleficence

According to the principle of beneficence, efforts should be made to protect and promote welfare; according to the principle of nonmaleficence, efforts should be made to minimize harm. These two principles are particularly complex when applied to the context of multifetal pregnancy. On the one hand, multifetal pregnancy reduction will be seen by some as protecting health and minimizing harm, by maximizing the woman's health and the health of her surviving neonates. On the other hand, multifetal pregnancy reduction will be seen by others as inflicting harm because it causes the loss of one or more fetuses.

Because of differing value systems, decisions based on beneficence and nonmaleficence may lead a woman toward either reducing or maintaining the multifetal pregnancy. For example, a woman who interprets the principle of beneficence as giving each fetus an equal chance for survival may opt to continue a multifetal pregnancy. In contrast, a woman who interprets the principle of beneficence to mean maximizing the chance of some surviving neonates by reducing the chance of miscarriage or maximizing the health of the children she gives birth to may opt for multifetal pregnancy reduction. The number of fetuses, the medical facts, the woman's own values, and her particular economic and social situations may change the balance regarding such decisions.

Justice

According to the ethical principle of justice, access to resources, including multifetal pregnancy reduction, should be equitably distributed within a society. When the current status of assisted reproduction in the United States is viewed through the lens of justice, inequities become apparent. Women who live in states that mandate insurers to cover the treatment of infertility have increased access to fertility services, as do women of higher socioeconomic status. Such women can often avoid treatments such as controlled ovarian hyperstimulation, which are associated with an increased risk of high-order multifetal gestations, in favor of safer treatments such as IVF. When economic factors are less pronounced, women are more likely to limit the number of embryos transferred in a given IVF cycle, knowing that if the cycle fails they will have the resources to attempt another treatment cycle. A review of IVF cycles across the country found that in states with complete insurance coverage for fertility treatments, there was a significant decrease in the percentage of triplet pregnancies (25).

Applying the principle of justice may affect decisions surrounding IVF in different ways. Some individuals may apply the concept of justice by suggesting that multifetal pregnancy reduction should be a covered medical service. Others may feel that covering IVF and limiting the number of embryos transferred, while limiting patient and physician autonomy, would lead to maximal justice by significantly reducing the incidence of multifetal pregnancies and the need for multifetal pregnancy reduction. Ideally, access to both the treatment of infertility and multifetal pregnancy reduction should be equitably distributed.

Patient Counseling

The following sections address the counseling of patients regarding multifetal pregnancy reduction. Such counseling should provide the patient with detailed information in a way that is understandable to her, is nondirective, and integrates the aforementioned ethical principles.

Nondirective Counseling and Informed Consent

Once a high-order multifetal pregnancy has been diagnosed, the physician should guide the patient in collecting data given her current medical situation (ie, her health, the number of fetuses present, and the risk of maintaining compared with reducing the pregnancy). Counseling regarding her options should be provided. Resources for providing such counseling include perinatologists, neonatologists, mental health professionals, child development specialists, support groups, and clinicians with expertise in multifetal pregnancy reduction. The potential health, psychologic, economic, and social risks specific to multifetal pregnancies should be addressed. The probability of specific adverse outcomes should be discussed, and it is the physician's ethical obligation to provide adequate information regarding diagnosis, prognosis, and alterna-

tive treatment choices, including the option of no treatment. Such information should reflect the particular patient's linguistic or cognitive limitations (23).

Once the physician provides medical recommendations, the patient must assess her personal value system and determine a course of action. Physicians can serve as guides and resources, helping each individual patient explore her values when faced with the novel situation of carrying a multiple gestation. Understanding these values will help the patient make decisions appropriate to her particular beliefs.

Although no physicians need to perform multifetal pregnancy reductions if they believe that such procedures are morally unacceptable, all obstetricians and gynecologists should be aware of the medical risks of multifetal pregnancy, the potential medical benefits of multifetal pregnancy reduction, and the complex ethical issues inherent in decisions regarding the use of multifetal pregnancy reduction. When a patient request for multifetal pregnancy reduction is discordant with the physician's value system, the patient should be referred to a physician with expertise in performing multifetal pregnancy reductions.

It is often difficult to convey the risks of a multifetal pregnancy to fertility patients, many of whom fear that they might never bear children. For many, the arrival of twins or more is seen as a positive outcome, and the physician must convey the risks to patients who often are willing and even eager to gestate a multifetal pregnancy. Understanding the unique viewpoint of the fertility patient is crucial to obtaining informed consent. The specific risks, including the increasing risk with increasing numbers of fetuses, should be discussed in detail.

In cases of high-order multifetal pregnancies, counseling should include the availability of multifetal pregnancy reduction. It should convey that multifetal pregnancy reduction increases the chance of achieving at least one live birth and decreases the risk of a spontaneous loss of the entire pregnancy (10). Multifetal pregnancy reduction decreases the risks associated with preterm delivery, whether in high-order gestations of quadruplets or more, in trichorionic triplets reduced either to twins or to singletons, or in a monochorionic pair in a triplet pregnancy (26). Reducing a pregnancy also decreases maternal risks, including hypertension, preeclampsia, and gestational diabetes.

Patients being counseled regarding multifetal pregnancy reduction should be made aware that the technology exists to test the fetuses for aneuploidy and morphologic and genetic anomalies before the reduction is performed. Although such technology will not be available to all patients because of geographic and financial constraints, the ethical principle of justice argues that its existence should be discussed. Decisions about multifetal pregnancy reduction might possibly hinge on the findings of such analyses, and patients should be aware of them.

Thorough counseling gives a woman the tools with which to decide whether or not to undergo a multifetal pregnancy reduction. The way in which a woman experiences her choice is as fundamental to her decision-making process as is the risk associated with any decision she makes. The concepts of "health," "illness," and "harm" are multidimensional, and that which justifies whether a multifetal pregnancy reduction is appropriate for a given individual has as much to do with her interpretation of a "good outcome" as do the medical facts (27).

In the end, whether a woman decides to maintain or to reduce a high-order multifetal pregnancy, she should be assured that she will receive the best available care (28). Physicians who provide care for patients with multifetal pregnancies should ensure continuity of care when referring them outside of their practices for consultation regarding multifetal pregnancy reduction. When referring the patient for consultation, the referring practitioner should do so in a timely fashion, explain to the patient the reason for the consultation, provide all necessary information to the consultant, and maintain continuity of care. When possible, social workers or other mental health professionals who have experience in caring for patients making decisions regarding multifetal pregnancy reduction should be incorporated into the patient care team.

The Decision-Making Process: Applying the Ethics

The ethical concepts discussed in this Committee Opinion may be used to help patients apply their personal values to decisions regarding multifetal pregnancy reduction. Such decisions have much to do with the relative weight a woman appropriates to a system of values. These values include values about discrete medical outcomes (ie, what decision would lead to the best medical outcome and least harm to the woman and her pregnancy), lifestyle issues such as socioeconomic considerations, and belief systems, including religious and moral beliefs (29).

Ultimately, respect for autonomy dictates that it is the patient who must balance the relative importance of the medical, ethical, religious, and socioeconomic determinants and pursue the best course of action for her unique situation. These are decisions that none other than the woman must make. She may wish to consult with others whose advice and counsel are important to her (30). Her reproductive liberty, as defined by respect for her autonomy, should and must be at the center of the ethical decision-making process.

Special Cases: Selective Reduction, Reduction Based on Fetal Sex, and Reduction to a Singleton

Selective Reduction

The case of selective reduction is somewhat different from that of multifetal pregnancy reduction. In multifetal pregnancy reduction, the fetus(es) to be reduced are chosen

on the basis of technical considerations, such as which is most accessible to intervention. In selective reduction, fetuses are chosen on the basis of health status or sex. When ultrasonography, aneuploidy screening, or evaluation for genetic diseases identifies a fetus with an abnormality, some will identify the anomaly as a specific reason for reducing a given fetus. In many cases, fetus(es) that are chromosomally abnormal or affected by a genetic disorder would be preferentially selected for reduction. Respect for autonomy is the principle that argues that it is the pregnant woman who will ultimately make this decision. Although some will critique the appropriateness of selective reduction based on disability rights, an analysis of such considerations is beyond the scope of this Committee Opinion (31).

Reduction Based on Fetal Sex

Before multifetal pregnancy reduction, some patients will undergo aneuploidy screening by chorionic villus sampling or amniocentesis. In such cases, the physician knows the sex of the fetuses. This information should not be withheld from the pregnant woman who requests it. However, aneuploidy screening for the express purpose of sex selection for social reasons is not appropriate (32).

Reduction to a Singleton

When multifetal pregnancy reduction is considered, the decision of how many fetuses to reduce may have as much to do with financial, social, or emotional concerns as with medical risks. For some women, a reduction to a singleton may be the preferred choice of action (10). There is some controversy as to whether women pregnant with twins should be offered reduction to a singleton. Physicians should consider offering this counseling based on their understanding of the particular patient and her values and circumstances.

Summary

Whether or not physicians choose to participate in multifetal pregnancy reduction, they should be knowledgeable about this procedure and be prepared to react in a professional and ethical manner to patient requests for information, intervention, or both. The first approach to the problem of multifetal pregnancies should be prevention. Although multifetal pregnancy reduction will be ethically acceptable to many as a response to an unintended contingency, in almost all cases, it is preferable to cancel a controlled ovarian hyperstimulation cycle when the ovarian response suggests a high risk of a multifetal pregnancy or to limit the number of embryos to be transferred. This will help prevent a situation in which the patient and physician need to consider multifetal pregnancy reduction (33). Incorporating the ethical frameworks presented in this Committee Opinion will help physicians counsel and guide patients when making decisions regarding multifetal pregnancy reduction.

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