Essay
Ginecol Obstet Mex 2025; 93 (10): 440-446.

https://doi.org/10.24245/gom.v93i10.294

Addressing the Challenges of Induced Fetal Asystole in Mexico: Ethical, legal, and clinical reflections.

Frente a los desafíos de la asistolia fetal inducida en México: reflexiones éticas, legales y clínicas

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Abstract

Fetal asystole presents some of the most ethically and clinically complex dilemmas in maternal-fetal medicine, particularly in the context of late termination of pregnancy. While advances in prenatal diagnostics have improved the possibilities for early detection and informed decision-making, equitable access to safe and dignified care remains a significant challenge, especially in settings where legal frameworks and clinical guidelines are unclear or inconsistent. This essay examines the complexities of induced fetal asystole inMexico, drawing on ethical principles, comparative legal analysis, and international experiences. It highlights the need for institutional protocols that are context-sensitive, ethically grounded, and aimed at protecting the rights and wellbeing of both patients and healthcare providers. Through a structured reflection, this essay contributes to the ongoing dialogue on reproductive justice, clinical safety, and shared responsibility in gestational care.

KEYWORDS: Induced fetal asystole; Feticide; Pregnancy termination; Reproductive health; Ethics; Fetal anomalies.

Resumen

La asistolia fetal inducida representa uno de los dilemas más complejos en la medicina materno-fetal, tanto en el plano ético como clínico, especialmente en el contexto de la interrupción del embarazo en etapas avanzadas de la gestación. Si bien los avances en el diagnóstico prenatal han ampliado las posibilidades de detección temprana y toma de decisiones oportunas, el acceso equitativo a una atención segura y digna sigue siendo limitado, particularmente en contextos donde los marcos legales y las guías clínicas son ambiguos o inconsistentes. Este ensayo analiza los desafíos relacionados con la asistolia fetal inducida en México, a partir de principios éticos, análisis legal comparado y experiencias internacionales. Se subraya la necesidad de establecer protocolos institucionales sensibles al contexto, con fundamentos éticos sólidos y orientados a proteger los derechos y el bienestar de las pacientes y del personal de salud. Mediante esta reflexión se busca contribuir al debate continuo acerca de la justicia reproductiva, seguridad clínica y responsabilidad compartida en la atención a la paciente embarazada.

PALABRAS CLAVE: Asistolia fetal inducida; feticidio; interrupción del embarazo; salud reproductiva; ética; anomalías fetales.

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Received: June 2025

Accepted: July 2025

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This article has been cited as:: Rodríguez-Sibaja MJ, JA, Ramírez-Calvo JA, Gallardo-Gaona JM, López-Rodríguez L, Rodríguez-Bosch MR, Valencia-Contreras C, Acevedo-Gallegos S. Addressing the Challenges of Induced Fetal Asystole in Mexico: Ethical, legal, and clinical reflections. Ginecol Obstet Mex 2025; (10): 440-446.

BACKGROUND

Discussing induced fetal asystole means confronting one of the most complex and controversial decisions in maternal-fetal medicine. Induced fetal asystole refers to the medical procedure that intentionally causes the cessation of the fetal heart (cardioplegia).[1,2] While increasingly recognized internationally as a critical component of termination of pregnancy at advanced gestations, induced fetal asystole remains controversial and unevenly regulated across health systems.

In Mexico, advancements in prenatal diagnostics coexist with the absence of clear legal frameworks or clinical guidance for managing pregnancies affected by lethal or severe fetal anomalies or significant maternal health risks. Within this regulatory vacuum, patients and healthcare professionals alike are left navigating clinical, ethical, and legal uncertainty.

This essay responds to that gap. It critically explores the ethical foundations, legal precedents, and international experiences surrounding induced fetal asystole, while proposing a context-sensitive framework for its implementation in Mexico. The aim is not only to safeguard the rights and well-being of pregnant individuals but also to reduce legal vulnerability and ethical burden among providers and to promote equitable access to reproductive care.

Contextualizing Induced fetal asystole in reproductive health

The recognition of sexual and reproductive rights as fundamental human rights by the United Nations has reshaped the global discussion surroundoing termination of pregnancy. Termination of pregnancy, particularly in situations involving lethal or severe fetal anomalies, or life-threatening maternal conditions, is increasingly viewed not only as a legitimate component of universal health strategies, but as a matter of justice, equity, and autonomy.[3,4]

A diagnosis of a congenital or genetic anomaly does not always occur early. While advances in prenatal diagnostics have significantly expanded the possibilities for early detection, some conditions require repeated evaluations, specialized tests, or only become apparent later in gestation.[5] These delays are further magnified in low-resource settings, including Mexico, where timely and equitable access to prenatal screening and diagnostic services remains a challenge. In such contexts, the timing of diagnosis is shaped not only by the nature of the fetal condition, but also by structural factors such as the availability of trained professionals, appropriate technology, and reliable follow-up systems.[6] As a result, many families receive devastating diagnoses late in pregnancy, just as the window for safe and timely decision-making begins to narrow.

At this stage, gestational age becomes a critical factor in the ethics and logistics of termination of pregnancy.[2,5,7,8] The concept of viability, defined as the gestational age at which a fetus can survive the neonatal period with available resources,[9] carries not only biological but also legal and emotional implications. In high-income countries, this threshold is generally established between 22 and 24 weeks, although survival rates vary significantly.[7-10] Resource disparities result in a more heterogeneous viability threshold in developing countries.[2,11] In Mexico, third-level hospitals generally consider 25 weeks as the practical threshold, with near-zero survival reported at 23-24 weeks of gestation.[12,13,14] These figures are not just clinical data; they are the backdrop against which women and their families must make some of the most difficult decisions of their lives.

In such circumstances, induced fetal asystole becomes a critical tool, as a means of aligning medical practice with ethical clarity and legal precau-

tion.[1,2,5] This highlights the urgent need to rethink how we manage late termination of pregnancy in Mexico, not only through clinical capacity, but through institutional frameworks that are consistent, compassionate, and respectful of rights.

Ethics at the edge of viability

Decisions regarding termination of pregnancy at advanced gestational ages challenge the ethical foundations of both reproductive care and perinatal medicine. When a fetus is diagnosed with a lethal or severely life-limiting condition, or when maternal health is at risk, the question of when and how to intervene shifts from clinical judgment to deeply moral territory. Induced fetal asystole lies at the intersection of these dilemmas.

The ethical justification for induced fetal asystole is grounded in the principles of autonomy, beneficence, and non-maleficence,[15,16] and can be articulated through three key concepts:

1. *Autonomy of the pregnant woman*. Ensuring that pregnant individuals receive complete and comprehensible information about the fetal condition, including prognosis and available options, upholds their right to make informed decisions about their own bodies and pregnancies.[15] But for that right to be genuinely exercisable, it must be supported by structural conditions that enable timely diagnosis, non-coercive counseling, and safe access to care. In late-term scenarios, these conditions are rarely optimal, especially where the legal framework surrounding termination is limited and often inconsistently applied.

2. *The fetus as a person*. The ethical status of the fetus, particularly at the threshold of viability, remains one of the most debated and emotionally charged aspects of termination of pregnancy. In bioethics, personhood is not considered a fixed status, but rather one often shaped by gestational age, the capacity for independent survival, and relational context. A pre-viable fetus is entirely dependent on the pregnant individual for survival, and its moral status is mediated through her autonomy. As viability approaches, ethical obligations shift: the fetus is increasingly considered through the principles of beneficence and non-maleficence. This does not imply that the fetus becomes autonomous, as it lacks the capacity to form its own interests or perspectives. Rather, it signals a growing professional and societal duty to acknowledge the potential for neonatal life.[15]

Ethical debates about late termination often focus on this evolving balance of obligations. Before viability, termination is ethically justified by the principles of autonomy and beneficence toward the pregnant person. After viability, the obligation to protect fetal life, grounded in beneficence, becomes more pronounced. However, in certain cases, termination may also be framed as beneficence toward the fetus, when the risk of severe and preventable neonatal morbidity justifies intervention. In such situations, the principles of autonomy and beneficence converge: honoring the pregnant individual's decision may also be the most ethically defensible course of action for the fetus. Termination after viability should therefore be restricted to cases of lethal or severe fetal anomalies with high diagnostic certainty and a poor prognosis.[15]

3. *Respect for the individual conscience of medical personnel*. Individual conscience, often shaped by personal moral or religious beliefs, can come into conflict with professional ethics, which are focused on patient care. From the provider's perspective, the absence of clear protocols amplifies the ethical burden. However, while it is legitimate for healthcare professionals to hold personal beliefs, these

https://doi.org/10.24245/gom.v93i10.294

should not obstruct a patient's access to care. Ethical practice requires that providers remain informed about termination of pregnancy procedures and their potential complications, and that they ensure timely referral when they are unable or unwilling to perform such interventions themselves.[15] In the context of late termination and induced fetal asystole, avoiding delays is essential to upholding patient rights and preventing avoidable harm.

Beyond these principles and clinical settings, the stigma surrounding termination at advanced gestation adds another layer of complexity. Public discourse often lacks nuance, framing these cases through binary lenses of right or wrong, life or death. Yet the reality is more ambiguous, shaped by grief, fear, and deeply personal circumstances. In this context, ethical frameworks must do more than categorize; they must make room for uncertainty and compassion, for both patients and healthcare professionals.

Legal frameworks: between progress and ambiguity

In Mexico, laws on termination of pregnancy, particularly at advanced gestational ages, are complex, inconsistent, and often ambiguous. Although the Federal Penal Code criminalizes abortion except in cases of rape or when the woman's life is at risk,[17] individual states retain autonomy to define their own regulations. Mexico City stands as a notable exception, permitting voluntary termination of pregnancy up to 12 weeks and allowing later terminations under specific circumstances, such as severe fetal anomalies or significant maternal health risks, provided there is appropriate medical endorsement.[18] Yet in most other states, access remains legally uncertain or practically unattainable.
Recent rulings by the Mexican Supreme Court (SCJN) have significantly reshaped the national discourse. In 2007, the Court upheld the constitutionality of Mexico City's abortion legislation. A decade later, in 2017, it declared the absolute criminalization of abortion unconstitutional, reaffirming the principles of reproductive autonomy and gender equality. Most recently, in 2023, it took a landmark step by decriminalizing abortion nationwide by invalidating penal code provisions that sanctioned both women and health care providers.[19,20,21] These rulings highlight the growing constitutional recognition of reproductive rights in Mexico. However, a substantial implementation gap persists: legal advances at the federal level have not yet been fully operationalized in clinical practice.

A comparative glance at other countries shows that legal frameworks vary not only in their degree of permissiveness, but also in how they operationalize late termination, particularly with regard to induced fetal asystole.[22] Colombia permits termination of pregnancy for any reason up to 24 weeks, and at any gestational age in cases of lethal fetal anomalies or significant maternal risk, while explicitly prohibiting unnecessary delays or judicial barriers.[23] Ireland adopts a multidisciplinary approach, requiring specialist certification for fatal fetal conditions, and recommends induced fetal asystole after 21 weeks and 6 days to prevent signs of life at birth.[1] The United Kingdom permits termination of pregnancy up to 24 weeks of gestation. Beyond that point, it is legally authorized in cases of severe fetal anomalies or risks to the mother's health. Within this framework, induced fetal asystole is routinely offered when termination of pregnancy is indicated for fetal anomalies diagnosed after 21 weeks and 6 days. Additionally, UK legislation explicitly recognizes selective induced fetal asystole in multifetal pregnancies.[5] In contrast, countries like Israel and Spain require committee approval or physician impartiality, but rarely address induced fetal asystole directly.[24,25]

What these models share is the recognition that law must do more than merely permit: it must

also provide guidance and protection. In the absence of clear procedural frameworks for late-term termination, particularly regarding induced fetal asystole, both patients and providers encounter an ambiguous landscape that could compromise access to equitable care and increase their exposure to ethical and legal liability.

Toward a national protocol for induced fetal asystole

As legal and ethical debates continue to evolve, healthcare institutions remain at the forefront of translating principles into practice. The development of a context-sensitive protocol for induced fetal asystole represents a tangible step forward. Rooted in ethical principles, aligned with international standards, and responsive to national realities, this proposed framework aims to guide institutional practice with consistency, safety and respect for human rights.

1. Case selection based on clinical severity and gestational thresholds. Induced fetal asystole should be considered as part of a termination of pregnancy procedure only under clearly defined circumstances:

a. after 24.0 weeks of gestation**,** in cases of confirmed severe fetal anomalies or genetic conditions incompatible with life or associated with profound and irreversible physical or neurological impairment.

b. between 22.0 and 24.0 weeks of gestation, if continuing the pregnancy poses a significant threat to the pregnant person´s health.

These criteria aim to balance the evolving ethical obligations associated with advancing gestational age with the clinical realities of fetal viability and maternal well-being.

2. Multidisciplinary review process. To ensure ethical rigor and institutional accountability, each case should be evaluated by a multidisciplinary committee. This should include maternal-fetal medicine specialists, neonatologists, geneticists, psychologists, social workers, and legal advisors. Other specialists (e.g., surgeons, cardiologists, neurologists) may be consulted when clinically appropriate. Beyond individual case evaluations, the committee should foster transparency through systematic documentation, staff training, and periodic audits that assess diagnostic accuracy, patient outcomes, and compliance with established protocols.

3. Counseling and consent as ethical imperatives. Pregnant patients facing induced fetal asystole must receive clear, compassionate, and unbiased counseling about the diagnosis, prognosis, and available management options. A multidisciplinary approach is essential to foster trust, support informed decision-making, and uphold patient autonomy. Informed consent should meet not only legal standards but also ethical expectations, ensuring clarity, voluntariness, and sensitivity to each patient's individual context and values.

4. Technical guidance rooted in safety and expertise. The recommended procedure for induced fetal asystole is ultrasound-guided intracardiac injection of KCL, performed exclusively by experienced maternal-fetal medicine specialists. Comprehensive documentation, detailing the procedure, medications administered, and confirmation of fetal demise, is necessary to ensure clinical accountability, transparency and adherence to ethical standards.[2,5,25,26] **Table 1**

5. Delivery care planning. Mode of delivery should be individualized according to obstetric considerations and maternal health status. Pre-procedure planning should include respectful attention to the patient's preferences regarding contact with the fetus or neonate, memory-making, and supportive rituals that may facilitate emotional and psychological closure.

 https://doi.org/10.24245/gom.v93i10.294

Table 1. Technical aspects of induced fetal asystole

1. Patient identification and preparation
Verify patient information (name, date of birth, RhD status, gestational age, and diagnosis). Record vital signs (heart rate, respiratory rate, temperature, blood pressure). Provide maternal anxiolysis if needed (e.g., lorazepam 2 mg or alprazolam 2 mg).
2. Sterile field preparation
Perform antisepsis of the abdominal area. Use sterile gloves, drapes, transducer cover and gel.
3. Ultrasound-guided needle insertion
Assess fetal position, placental location, and movement patterns to plan a safe needle trajectory. Insert a 20–22G needle into the fetal heart, ensuring continuous visualization of the needle tip.[1]
4. Potassium chloride (KCl) injection
Administer 22 mEq of KCl at 22 weeks of gestation, increasing by 1 mEq for each additional week.[2–4] Optional: Fetal analgesia with intramuscular fentanyl (20 mcg/kg) and vecuronium (0.2 mg/kg) or sufentanil (5 mcg via the umbilical vein).[2,3] If asystole does not occur within 30–60 seconds, repeat the injection.[2]
5. Asystole confirmation
Document asystole over 2 minutes and repeat ultrasound confirmation 30–60 minutes later.[2]
6. Documentation and post-procedure care
Record procedure details (e.g., needle insertion time, medications administered, doses, and fetal demise confirmation). Administer anti-D immunoglobulin to Rh-negative women without confirmed fetal Rh genotype.[1] Monitor the maternal potassium level if concerns about absorption arise.[3]

6. Follow-up care and reproductive counseling. Post-procedure care must extend beyond medical discharge and encompass the physical, psychological and reproductive needs of the patient. It should include:

a. Obstetric follow-up, tailored to the mode of delivery and the patient´s medical history, including lactation suppression or alternative options as appropriate as well as counseling on contraception and reproductive planning based on the patient's preferences and future fertility goals.[1]

b. Psychological support for patients and families, recognizing the emotional impact of grief and trauma.[5,27]

c. Post-mortem evaluation, including clinical assessment, relevant laboratory studies, and a complete autopsy when feasible, to confirm the prenatal diagnosis and inform future reproductive decisions.[28]

d. A multidisciplinary consultation to review findings, address any remaining questions, concerns, and offer closure in a supportive and respectful manner.

Protocols alone cannot eliminate the ethical complexity of induced fetal asystole, but they can offer a common language, alleviate moral distress, and help ensure that decisions; however difficult, are made with transparency, compassion, and clinical integrity.

Looking forward

Developing a clear institutional framework for induced fetal asystole in Mexico is not only a clinical necessity but also an ethical and social responsibility. As argued throughout this essay, the absence of guidance in managing late-term pregnancy termination creates uncertainty for both patients and healthcare providers. By integrating clinical expertise, ethical reasoning, and evolving legal standards, it is possible to envision a more coherent and compassionate approach to reproductive care.

Rather than offering a definitive answer, the proposed framework seeks to contribute to an ongoing conversation. In a setting like Mexico, where legal progress coexists with structural and operational gaps, developing institutional protocols represents a tangible step toward protecting

rights, reducing risk, and dignifying maternal and perinatal health services.

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