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Bioethical Decision-Making For Extremely Premature Births Guided by Dialogue and Pragmatic Principles

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Abstract

Moral values in healthcare are diverse and inherently subjective, often differing across stakeholders. Such disagreements can hinder meaningful dialogue and marginalize alternative perspectives. Extremely premature births illustrate how conflicts can become counterproductive when competing interests, cultural misinterpretations, limited evidence assessment, and hierarchical pressures operate without the guidance of objective reasoning. Embracing uncertainty, equitably distributing risk, and recognizing the boundaries of treatment are virtues, not mere relativism, and are particularly vital in settings with scarce resources. We propose that dialogics fosters mutual understanding by: i) helping beliefs evolve beyond personal bias, ii) directing disputes toward pragmatic resolution (where the validity of any stance is tested through experience), and iii) acknowledging value pluralism (the irreducible, conflicting, and ultimately incommensurable nature of human values). This article presents a structured Point-Counterpoint on controversies surrounding extreme prematurity, an objective table of neurodevelopmental outcomes, and a dialogics model designed to enhance shared empathy rather than create opposing camps. Our aim is to narrow the comprehension gap between physicians and bioethicists. Dialogics recognizes the inevitability of conflicting human interests, understanding that universally satisfactory solutions are impossible, as every choice entails trade-offs. Cultivating collective awareness through dialogics and pragmatism harmonizes objective evidence appraisal with moral and cultural values, embodying a rare ethical construct that functions simultaneously as process and goal.

Keywords: Morality, Extreme premature birth, Ethics-medical, Value pluralism, Decision making, Uncertainty

Background

Providing a precise summary of health outcomes and the bioethical challenges surrounding extremely premature birth is inherently difficult, and may even be unattainable. The periviability literature is highly heterogeneous, often allowing selective emphasis on studies or viewpoints that align with personal or institutional biases rather than reflecting broad consensus. Diverse cultural and religious values, conflicts of interest, financial considerations, resource constraints, and the socioeconomic pressures faced by families warrant greater attention, yet they remain largely unexamined. To address these complexities, we propose an alternative framework grounded in dialogics and pragmatism, aiming to bridge the understanding gap both within and between physicians and bioethicists.

Strongly held beliefs about palliative care versus neonatal intensive care for extremely premature infants profoundly influence both health outcomes and social implications, yet receive surprisingly limited scrutiny compared to medical treatments and interventions. Questions surrounding which family preferences are considered acceptable, which advanced technological therapies are deemed experimental, and whether cultural

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differences can be reconciled with common moral principles, all involve deeply personal emotions and convictions [1–4].

Clinicians often recognize uncertainty but tend toward risk aversion. Rigid thresholds that ignore the inherent ambiguity of many aspects of extreme prematurity frequently serve the interests of those in positions of authority. The Sorites Paradox is highly relevant to bioethical reasoning: when clear distinctions—"this is X, that is Y"—cannot be confidently made, it is prudent to avoid inflexible positions that declare "X is right" and "Y is wrong" [5–8].

Moral statements implicitly define what is immoral, creating an inherent source of conflict. Disputes over extreme prematurity rarely function as exercises in tolerant disagreement because emergent medical decisions demand binary choices. Critical judgments must be made swiftly regarding fetal monitoring, antenatal corticosteroids, cesarean delivery, or intubation. Immediate decision paths may appear convenient for some stakeholders but can later carry regret and unforeseen consequences. We contend that such dissensus is intrinsic to extreme prematurity and should not be viewed as a problem to eradicate; rather, it should be acknowledged and managed interactively alongside elements of consensus [9–13].

Every choice carries potential drawbacks, making extreme prematurity a poignant example of human suffering and tragedy. No approach guarantees safety, eliminates pain, or ensures well-being. Family responses and physicians' decision-making evolve over time as perceptions of "right" and "wrong" shift. Clinicians should avoid framing decisions regarding periviability as opportunities for pregnant women, families, or providers to achieve moral heroism [14, 15].

Our objectives are threefold: i) to summarize recent reports on long-term neurodevelopmental outcomes of extremely premature infants, supporting objective shared decision-making (Additional file 1: Table S1); ii) to present a practical Point-Counterpoint highlighting divergent perspectives on extreme prematurity **(Table 1)**; and iii) to demonstrate how dialogics and pragmatism foster listening, information exchange, and relational interactions that cultivate collective consciousness, enhance empathetic understanding, and support bioethical decision-making. We encourage readers to engage with this manuscript, as appreciating the principles of dialogics and pragmatism can enrich their contributions to navigating the complexities of extreme prematurity.

Table 1. Point—Counterpoint Dialogic Summary of Key Perspectives and Issues on Extremely Premature Birth—Neonatal Intensive Care vs. Palliative Care

Neonatal Intensive Care for Extremely Premature Infants	Palliative Care for Extremely Premature Infants
Gestational age estimates carry a margin of error (~±1 week), so a 23-week infant could be 24 weeks.	Gestational age estimates are similarly imprecise (~±1 week), meaning a 24-week infant could be 23 weeks.
While gestational age is a key predictor of mortality and morbidity, it is not exact and should not be the only factor in determining outcomes.	Birth weight is as reliable as gestational age in predicting mortality and neurodevelopmental impairment (NDI). Additional factors like ultrasound-based fetal weight estimates, sex, multiple births, fetal anatomy, maternal biomarkers, medical history, and demographics enhance outcome predictions.
Using gestational age as a strict cutoff for care decisions is biologically arbitrary (e.g., offering NICU care at 24 weeks but palliative care at 23 6/7 weeks).	Published guidelines rely on gestational age, but rigid cutoffs lack logical consistency (e.g., recommending palliative care at 21 6/7 weeks but NICU care at 22 weeks).
Survival predictions are unreliable in NICUs favoring palliative care, creating a self-fulfilling cycle of higher mortality.	Mandating NICU care undermines shared decision-making and family preferences, leading to a self-fulfilling cycle of pain, suffering, morbidity, late hospital deaths, and NDI.
All extremely premature infants (EPIs) should receive initial resuscitation with daily reassessments; withdrawing life support is ethically acceptable only after a "trial of therapy" to better inform prognosis.	EPIs who die later in the hospital or develop NDI often lack early, severe conditions justifying withdrawal of care. Stopping life support later may conflict with the initial rationale for NICU care, creating ethical inconsistency.
Some EPIs survive and thrive, but this is hard to predict in the delivery room or early days of life.	EPIs may seem stable initially but later face significant morbidity, late death, or NDI, which is challenging to predict accurately at birth or shortly after.

NICU outcome data presented as percentages can confuse families and may mislead if framed with bias.	All major consensus statements advocate for shared decision-making supported by clear, evidence-based short- and long-term outcome data, using numbers and percentages effectively.
Advancing medical science requires exploring new treatments. Denying potentially beneficial technology is coercive and risks abuse of power.	Pregnant women and families have the right to refuse unproven or high-risk NICU or maternal treatments due to potential pain, late mortality, NDI, chronic health issues, and other unpredictable outcomes.
EPI survival rates have improved and may continue to do so with ongoing efforts.	The literature often underreports the extent of pain, NICU deaths, or post-discharge mortality. There is no consensus on how much suffering or death justifies experimental treatments among physicians, families, or society.
Withholding and withdrawing life support are morally equivalent actions.	While withholding and withdrawing life support may be theoretically equivalent, they are not always ethically equivalent for families or providers, who may see early palliative care as a way to reduce unnecessary suffering and moral distress.
Core Issue: Is it justifiable to deny an EPI, or any sentient human, a chance at life support?	**Core Issue**: Is a pregnant woman morally obligated to consent to NICU care for an EPI, regardless of her circumstances, preferences, risks to her health, or the uncertain long-term outcomes for the child?
A key challenge in shared decision-making is reducing physician bias.	A key challenge in shared decision-making is ensuring families understand that decisions must often be made quickly, and indecision is itself a choice.
All human life is sacred, and medical interventions extend divine will in determining life and death.	The concept of "sacred" is not universal; families and physicians differ by culture or belief, and not all view humans as "persons" with equal rights, especially in cases of severe birth defects where NICU limits are widely accepted.
How can death ever be in an infant's best interest? Unless death is nearly certain, NICU care should be attempted.	Comparing death to outcomes like pain, suffering, or severe NDI reflects diverse values and human complexity. The "best interests" of the woman, family, and infant should all be considered.
Palliative care may feel like abandoning hope, have an unpredictable trajectory, and lead to family regret.	Palliative care can be a compassionate, well-structured approach that prioritizes dignity, family support, and minimizing suffering. NICU care, with its risks of pain, late death, and NDI, can also lead to regret.
In some countries, therapeutic abortion is prohibited at gestational ages where EPIs receive NICU care, making palliative care inconsistent with local laws.	In some countries, therapeutic abortion is allowed at these gestational ages, so mandating NICU care conflicts with legal options.
Palliative care results in infant death without offering a chance at life, despite the potential for healthy outcomes or manageable chronic conditions.	Mandating NICU care poses minimal risk to physicians but places significant burdens—physical, emotional, and financial—on families and causes suffering for EPIs.
Religious families may choose NICU care for non-evidence-based reasons, and their beliefs are generally respected. Faith traditions vary widely.	Religious families may opt for palliative care for non-evidence-based reasons, and their preferences are also respected. Faith traditions show significant variability.
Women with complex pregnancies (e.g., advanced age, infertility, or serious medical conditions) should be supported if they choose NICU care for their EPI.	Women in such circumstances should not be presumed to want or required to choose NICU care for their EPI.
Lawsuits for wrongful EPI deaths have been filed and settled.	Lawsuits for wrongful EPI life (prolonging suffering) have also been filed and settled.
Physicians and bioethicists advocating palliative care may be a minority among NICU proponents, particularly neonatologists.	NICU care advocates often focus on disputes with palliative care supporters rather than acknowledging their primary disagreement is with families choosing palliative care.
Physicians favoring palliative care may be influenced by disinterest in EPI care, fixed salaries, weaker clinical skills, burnout, or personal beliefs not shared by families, or lack of empathy for those with NDI.	Physicians favoring NICU care may be driven by prestige, research goals, career incentives tied to EPI care, financial rewards, personal beliefs, or a tendency to view patients as victims needing rescue.
Physicians who are parents, especially of EPIs, may offer unique perspectives relevant to families and providers.	Personal experience as a parent or with an EPI does not grant physicians greater moral authority. Physicians must avoid implying superior ethical judgment, regardless of parenthood.
The death of an EPI is as morally significant as that of an older child or adult. Palliative care	Comparing the moral weight of EPI deaths to those of older individuals is subjective and varies by culture and family experience, especially for those who have faced such losses.

undervalues EPI lives compared to older individuals who would receive intensive care.	
EPI care costs are relatively low compared to adult intensive care with similar or worse prognoses, and EPI care can yield acceptable quality of life.	EPI care diverts resources from more cost-effective healthcare for women and children, impacting population health. Families bear significant financial and opportunity costs for long-term EPI care, which are often overlooked.
Adults with comparable mortality and morbidity risks to EPIs often receive intensive care without debate, so treating EPIs differently is unfair.	Adults (or their surrogates) with similar risks can choose palliative care without controversy, unlike EPIs.
Many surviving EPIs do not have significant NDI, supporting broad NICU care. If 35–45% of survivors have significant NDI, 55–65% do not.	Significant NDI includes cognitive and motor deficits >1–2 SD below the mean, and many EPIs face additional neurobehavioral and psychiatric issues. No notable improvement in NDI rates for 22–24 week infants has occurred in 30 years.
Some adolescents and adults with NDI report high quality of life and achieve similar social and functional outcomes as term-born individuals.	Some with NDI report lower quality of life than term-born peers, and parents often perceive declining quality over time. Severe NDI prevents reliable quality-of-life assessments.
Judging individuals with NDI as less valuable is arbitrary; defining "normal" versus "disabled" neurologic function is subjective.	Preventing brain injury is a clear priority. NDI is universally seen as undesirable, not a "neurodiversity" condition families would choose.
Palliative care advocates may lack compassion for EPIs and families, prioritizing convenience or showing apathy, which fosters nihilism.	NICU care advocates may confuse compassion with pity, using their authority to elevate their status while diminishing families. This also perpetuates nihilism.
Uncertainty about outcomes often leads physicians to default to NICU care.	Families focus on risk (harm probability), and uncertainty or ambivalence may lead them to prefer palliative care.
Some use the term "Gray Zone" for extreme prematurity, a shrinking period where outcomes are so uncertain that either NICU or palliative care is reasonable.	Others prefer "Zone of Parental Discretion," a culturally variable period where uncertain outcomes justify family choice of either NICU or palliative care.

Dialectical thinking, structured as thesis–antithesis–synthesis, presumes a continuous trajectory toward an ultimate goal or universal truth. This framework is particularly alluring in healthcare, where absolutism, advanced technology, and scientism dominate the cultural landscape. Absolutism expects individuals to conform to the dominant cultural, religious, or political norms, while scientism elevates the scientific method and technology as the definitive solutions to human challenges [16–18]. By contrast, dialogics emphasizes that historically, no complex ethical issue has ever had a wholly rational, objective, or universally satisfying resolution [19–21].

Dialogics is especially well-suited to addressing extremely premature births because it acknowledges that communication and information exchange are multidirectional and resist simple summarization. Words, data, and interpretations are continually shaped by interaction and flux; individuals bring inherent biases and cultural influences, yet these are not necessarily immutable [18–20, 22, 23].

Moral intuitions are neither rigid deontological rules nor precisely calculable utilitarian formulas. Instead, they emerge from biological, social, and ideological factors shaped through human evolution [24]. When integrated into reflective dialogic processes, these intuitions contribute to a shared collective consciousness [25]. The present continually informs our understanding of the past, just as past experiences shape present judgments. Within dialogics, the weight and credibility of any individual's beliefs or authority vary according to context and specific issues, operating through interactive networks rather than hierarchical structures [26].

Dialogics rejects absolutism and embraces value pluralism, which is distinct from moral relativism. Value pluralism recognizes that core human values frequently conflict, may be incommensurable, and are often irresolvable without invoking hierarchies or power structures. In contrast, moral relativism incorrectly assumes that two judgments that appear morally different are in fact equivalent [16, 17, 27]. Dialogics also reinforces pragmatism: the validity of any belief or policy is ultimately demonstrated through the cumulative outcomes of real-world experience. Pragmatism emphasizes empirical truth, not compromise; it serves as a tool for objective fact-finding rather than a framework of opinions detached from principle [28].

Main Text (Dialogic Discussion)

Author A: Anxiety often arises when individuals deny their own responsibility. We possess the freedom to act authentically and make accountable choices without deferring to external authority or supernatural beliefs. In the context of extreme prematurity, we sometimes mask this anxiety through unchecked interventionism and reliance on technology (scientism). When we evade the responsibility of collaboratively determining what truly matters for the community in the present moment, we inadvertently reinforce dysfunction in healthcare, and in some cases, nihilism [29].

Author B: Decisions concerning extremely premature infants are profoundly consequential. Families must retain the opportunity to exercise self-responsibility in these choices [30]. At the same time, appeals to external authority or religious frameworks should not be dismissed. Supernatural beliefs provide some families with coping mechanisms in the face of life-and-death uncertainty [31]. Ignoring such values may foster nihilism, yet any belief system—including supernaturalism—can lead to requests for care that physicians might consider ethically problematic.

Author A: Physicians often conflate compassion with pity. True compassion involves genuine concern for another's suffering and is inherent to human nature. Pity, however, elevates oneself by framing others as weak or dependent. Authentic meaning arises from empowering others through assistance, whereas pity falsely positions us as superior, reinforcing vulnerability and dependence [32, 33].

Author B: Instead of overemphasizing the distinction between compassion and pity, communication with families should reflect empathy and support: "I understand you would prefer not to face this situation, but here we are, and I am here to guide and support you." This approach does not imply taking over decision-making. Delivering truthful, balanced, and evidence-based information—including the frightening or hopeful aspects of care—is essential for informed consent [34].

Author A: Contemporary discourse, particularly on social media, often frames conflict as an issue of honesty, but the central problem is actually sincerity. Sincerity is frequently mistaken for honesty: deeply held personal convictions become treated as inviolable. This tendency can undermine dialogics and pragmatism, as individuals assert personal rights over collaborative reasoning. In periviability controversies, physicians may project sincerity as part of their authority; however, one can be sincere without being genuinely honest, which risks replacing integrity with mere appearance [35].

Author B: Tolerance is a cornerstone of dialogic engagement in periviability contexts. When answering value-laden questions such as, "What would you do, doctor?" responses are valid only if physicians disclose their own values and potential biases [36]. Sincere answers that withhold evidence-based information conflict with authentic dialogics. Examples of inappropriate responses include statements like "There is nothing we can do at 22 weeks" or "Babies born at 25 weeks do well, so intensive care is always the right choice." Physicians must recognize that evidence can be framed positively ("survival," "no neurodevelopmental impairment"), negatively ("death," "neurodevelopmental impairment"), or honestly by presenting both perspectives together (Additional file 1: Table S1).

Author A: We recognize and respect when pregnant women express their religious values. However, physicians should not presume that patients—or colleagues—wish to know or align with the practitioner's personal religious beliefs. Introducing religious or political doctrines is particularly problematic for pregnant women due to their vulnerability; they require empathetic understanding and medical expertise rather than the imposition of personal bias or absolutist positions. Deeply religious individuals may choose palliative care, while others of equal faith opt for intensive care in similar circumstances. Integrating this reality of value pluralism can challenge physicians [24, 37].

Author B: Most people operate within a worldview that shapes their decisions. The role of the physician, from a dialogic and pragmatic perspective, is not primarily to decide for the patient, but to clarify options, provide guidance, and support reasoned, compassionate decision-making. When physicians are transparent about their role, their personal beliefs should minimally influence the pregnant woman's choices [38, 39]. Physicians should also recognize that judgments of whether specific neurodevelopmental impairments are "significant" differ between institutions, countries, and among families, highlighting the absence of universal categories for quality of life or child value.

Author A: Ambiguity often fuels wishful thinking, leading to rigid declarations of "right" and "wrong," which reduce ethical deliberation to "I think this is right; you should agree." Physicians inadvertently create tragedy when they treat lines-of-demarcation in ethical dilemmas as absolute, even though such boundaries are rarely logically or clinically definitive (Sorites Paradox). These rigid demarcations often reflect hierarchical power structures rather than objective reasoning [27, 40, 41].

Author B: In practice, certain boundaries are necessary for clarity and implementability. Consider the voting age in democracies: even if some 17-year-olds could make informed choices, a fixed age of 18 provides a clear, manageable standard. Similarly, when healthcare teams face a spectrum of moral perspectives, establishing practical lines-of-demarcation can facilitate coherent decision-making. These lines should remain flexible, adapting to new sociological, epistemological, or medical insights [42].

Author A: Although physicians generally endorse evidence-based medicine, its application in periviability decisions is inconsistent. Standardized informed consent is unevenly applied—for example, emphasized for surgery but not for broader life-support decisions [43, 44]. Extreme prematurity involves high uncertainty, risk, and experimental interventions. Neonatologists should not assume that specialized medical knowledge automatically confers moral authority. Compassion and evidence-based practices, centered on the family, must guide decision-making from the outset—not only after NICU admission [11, 12].

Author B: Structured, informed consent is critical. Providing families with relevant information underpins autonomy and supports surrogate decision-making [45]. While technical content and volume can be overwhelming, studies of decision-support tools indicate that parents often find more information preferable, and under-informing is a greater barrier to informed consent than over-informing [46, 47].

Author A: Although survival rates for extremely premature infants are improving, rates of neurodevelopmental impairment—especially under 25 weeks gestation—remain static or may be worsening when broader neuropsychiatric outcomes are considered (Additional file 1: Table S1) [48]. Quality of life tends to be lower in surviving extremely premature children as they reach adolescence and adulthood [49–52]. Advocates of universal intensive care often conflate improved survival with improved long-term outcomes, justifying ever-expanding interventions without evidence of enhanced comprehensive neurodevelopmental results [53, 54]. Conscience-based choices are bidirectional: opting out of palliative care or intensive care are both ethically legitimate. Physicians supporting palliative care are no more morally implicated in an infant's death than a physicist is responsible for the effects of gravity [55, 56].

Author B: Fear of death is a universal human concern, and for physicians, this extends to the fear of inadvertently causing death. This may create a cognitive bias favoring intensive care over palliative options. Reflecting on mortality and the moral status of the fetus or newborn encourages physicians to examine empirical experiences of families from diverse cultural and social backgrounds, who have navigated different care pathways, thereby informing long-term outcomes [57, 58]. Expanding research on how physicians experience fear related to "causing death" or "producing children with neurodevelopmental challenges" could enhance our understanding of professional normative perspectives.

Author A: Some healthcare objectives are straightforward—providers receive fixed funding to care for a defined number of patients each year. Achieving these objectives necessitates difficult prioritization decisions, each with trade-offs [59, 60]. Allocating $1000 here precludes spending it elsewhere, a reality routinely accepted outside healthcare, such as in household budgets, public services, and infrastructure. Neonatology, like all healthcare domains, must operate within evidence-based, population-level priority frameworks [61, 62].

Author B: Physicians are not trained economists. While resource awareness is important, our primary focus must remain on the care of present patients with available resources. Peter Singer's "drowning child" analogy illustrates this: we would rescue a nearby child even at minor personal cost, yet might overlook a distant child in crisis.

Author A: Health equity is an aspirational ideal rather than a consistent reality. In the U.S., significant resources are expended on organ transplants in older adults, high-cost genetic therapies, and extremely premature infants, yet routine prenatal care, vaccinations, and essential medications often remain financially inaccessible to families. The complex mix of uncertain outcomes, unproven interventions, and high costs in extreme prematurity challenges family well-being, so palliative care should not be mischaracterized simply as a cost-saving measure [62–66].

Author B: Infant mortality highlights inequities. In 2019, Canada's overall infant mortality rate was 4.4 per 1,000 live births, but it reached 16.7 in Nunavut compared with 4.5 in Ontario [67]. These persistent disparities reflect systemic injustice over the past two decades. Rising survival rates among extremely preterm infants during the same period, as shown in Additional file 1: Table S1, present a complex ethical question: how do we reconcile improved survival with persistent subpopulation inequities?

Author A: Extremely premature birth poses substantial health risks to pregnant women [68, 69]. Cesarean section rates are reported at 31% for 22–23 week infants and 69% for 24–25 week infants [54]. Obstetricians' primary duty is to safeguard maternal autonomy and health, ensuring that women are not subjected to undue risk driven by neonatal intensive care priorities.

Author B: Protecting patient autonomy and maternal health is essential, as maternal well-being directly affects fetal outcomes. Evidence regarding routine cesarean sections in extreme prematurity is inconclusive, complicating decisions about whether to pursue palliative or intensive care for the infant [70]. Shared decision-making should guide cesarean decisions when intensive care is planned [11, 12, 30, 71].

Author A: Given that most 22–23 week infants and many 24-week infants receiving intensive care either die in the NICU or survive with major neurodevelopmental and chronic health issues (Additional file 1: Table S1), NICUs and physicians advocating aggressive care at these gestational ages should assume full financial responsibility, independent of insurers, governments, or families. This approach would lend credibility to programs promoting themselves as "proactive" or "positive" [53, 54].

Author B: Is it ethically eugenic to withhold life-sustaining interventions from extremely premature infants based on gestational age? Providing care selectively, without acknowledging the possibility of error or potential harm, fosters a false sense of infallibility. Framing palliative care as inherently negative and intensive care as inherently positive is misleading. This perspective contrasts with the growing acceptance of medical assistance in dying, where individuals may choose death to avoid suffering and impairment. Should pregnant women have the surrogate authority to allow their extremely preterm infant to die, particularly when some societies permit autonomous adults to elect euthanasia? Do we possess sufficient certainty about the "best interests" of each extremely preterm infant to override surrogate decision-making?

Author A: NICUs with high utilization of palliative or intensive care for 22–24 week infants must clearly demonstrate how authentic shared decision-making occurs. This transparency aligns with authoritative consensus recommendations [12, 30, 71]. Hospitals that do not provide both care options should offer safe transfer to institutions that respect maternal well-being and informed choice.

Author B: High-risk pregnancies complicate transfers, as some women are clinically unstable. These patients may deliver at hospitals unable to fully honor informed decisions due to limitations in expertise, staffing, or equipment, potentially leading to preventable mortality or morbidity.

Author A: Physicians are neither inherently more rational nor impartial than the general population and deserve similar scrutiny as other professionals, including politicians, scientists, and educators. Humans tend to label what they favor as "good" [24, 25, 27]. Physicians and bioethicists must acknowledge that no absolute or supernatural "truths" exist in nature, religion, science, or philosophy to dictate ethical behavior [16, 18, 21]. Society functions best using pragmatic reasoning, justice, compassion, and dialogic engagement [16, 19, 20]. Scientism and technological authority should not mask hierarchical or biased ideologies. Too often, personal biases are disguised as objective facts, covering anxiety and uncertainty with purported expertise [37, 72, 73].

Author B: Ideally, care options for extremely preterm infants should exist in equipoise—intensive care may be viewed as experimental, whereas palliative care can be seen as discriminatory [74–76] **(Table 1)**. Enabling pregnant women to participate in comprehensive longitudinal research on decision-making, family perspectives, and long-term outcomes can mitigate biases and advance justice and compassion. Special focus should be given to comparing experiences of families choosing palliative care with those opting for intensive care.

Conclusion

Suffering is an intrinsic and universal aspect of human existence. How we reduce unnecessary anguish while nurturing the will to thrive is central to a civilized society [16, 77]. Humanity draws insight from diverse sources—philosophy, religion, science, literature, and even quantum physics—but all converge on the wisdom of dialogics: the capacity to communicate, learn, and adapt without demanding immediate consensus or definitive solutions [78–80].

We have emphasized pragmatism and value pluralism as guiding mindsets, shaped through interactive relationships. The aim is to cultivate a collective consciousness, rather than impose dogma or claim access to mythical objective truths, fostering understanding among bioethicists and physicians alike. Dialogics accepts suffering as unavoidable yet foundational for navigating the ethical complexities of extremely premature birth. Human will-to-flourish is both an individual drive and a communal opportunity, reflecting our inherently social nature. Dialogics represents a rare ethical construct—simultaneously a means and an end—of critical importance in both practice and reflection.

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References

1. Gillam L. The zone of parental discretion: an ethical tool for dealing with disagreement between parents and doctors about medical treatment of a child. Clin Ethics. 2016;11(1):1–8.
2. Stiggelbout AM, Pieterse AH, De Haes JC. Shared decision making: Concepts, evidence, and practice. Patient Educ Couns. 2015;98:1172–9.
3. Silverman WA. The line between knowing and doing: medicine's dilemma at the end of the twentieth century. Arch Dis Child. 1994;71:261–5.
4. Myrhaug HT, Brurberg KG, Hov L, Markestad T. Survival and impairment of extremely premature infants: A meta-analysis. Pediatrics. 2019;143(2): e20180933.
5. Kipnis K. Harm and uncertainty in newborn intensive care. Theor Med Bioeth. 2007;28:393–412.
6. Tyson JE, Stoll BJ. Evidence-based ethics and the care of extremely pre- mature infants. Clin Perinatol. 2003;30:363–87.
7. Tannsjo T. Should parents of neonates with bleak prognoses be encouraged to opt for another child with better odds? On the notion of moral replaceability. Pediatrics. 2018;142(s1):e20180478F.
8. Boss RD, Henderson CM, Wilfond BS. Decisions regarding resuscitation of extremely premature infants: Should social context matter? J Am Med Assoc Pediatr. 2015;169(6):521–2.
9. Gillam L, Wilkinson D, Xafis V, Isaacs D. Decision-making at the borderline of viability: Who should decide and on what basis? J Pediatr Child Health Care. 2017;53:105–11.
10. Kidszun A, Matheisl D, Tippmann S, Inthorn J, Mahmoudpour SH, Paul NW, et al. Effect of neonatal outcome estimates on decision-making preferences of mothers facing preterm birth: a randomized clinical trial. JAMA Pediatr. 2020;174(7):721-2. doi:10.1001/jamapediatrics.2020.0235.
11. Sullivan A, Cummings C. Shared decision making in the NICU. NeoReviews. 2020;21(4):e217–25.
12. Raju TNK, Mercer BM, Joseph GF. Periviable birth: executive summary of a joint workshop by the Eunice Kennedy shriver national institute of child health and human development, society for maternal-fetal medicine, American academy of pediatrics, and American college of obstetricians and gynecologists. J Perinatol. 2014;34:333–42.
13. Wilkinson D, Savulescu J. Ethics, conflict and medical treatment for children: from disagreement to dissensus. Edinburgh: Elsevier; 2019.
14. Harrison H. The offer they can't refuse: parents and perinatal treatment decisions. Semin Fetal Neonatal Med. 2008. https://doi.org/10.1016/siny.2008.03.004.
15. Kaempf JW, Dirksen K. Extremely premature birth, informed written consent, and the Greek ideal of sophrosyne. J Perinatol. 2018;38:306–10.
16. Barzun J. From Dawn to Decadence: 500 years of Western Cultural Life 1500 to the present. New York: HarperCollins Publishers; 2000.
17. Berlin I. The Crooked Timber of Humanity. Princeton: Princeton University Press; 1990.
18. Rorty R. Philosophy and Social Hope. London: Penguin Books; 1999.
19. Bakhtin MM. The Dialogic Imagination. In: Holquist M, editor. Austin: University of Texas Press; 1981.
20. Bohm D. On Dialogue. In Nichol L, editor. London: Routledge; 1996.
21. Grayling AC. The History of Philosophy. New York: Penguin Press; 2019.

22. Farnsworth W. Classical English Style. Boston: David R. Godine Publisher; 2020.
23. Morson GS. The Long and Short of It: From Aphorism to Novel. Stanford: Stanford University Press; 2012.
24. Haidt J. The Righteous Mind: Why Good People are Divided by Politics and Religion. New York: Rutgers University Press; 2012.
25. Nagel T. Types of intuition. Lond Rev Books. 2021;43(11):3–8.
26. Rovelli C. Helgoland: Making Sense of the Quantum Revolution. London: Penguin Random House Ltd; 2021.
27. Berlin I. The Proper Study of Mankind. New York: Farrar, Strauss, and Giroux; 1998.
28. Menand L. The Metaphysical Club. New York: Farrar, Strauss, and Giroux; 2001.
29. de Beauvoir S. The Ethics of Ambiguity. New York: Kensington Publishing Corporation; 1976.
30. Lemyre B, Moore G. Canadian paediatric society fetus and newborn committee. Counselling and management for anticipated extremely preterm birth. Paediatr Child Health. 2017;22(6):334–41.
31. Orr RD, Genesen LB. Requests for “inappropriate” treatment based on religious beliefs. J Med Ethics. 1997;23:142–7.
32. Safransky R. Schopenhauer and the Wild Years of Philosophy. Cambridge: Harvard University Press; 1990.
33. Nihilism GN. Nihilism. Cambridge: Massachusetts Institute of Technology Press; 2019.
34. Beauchamp TL, Childress JF. Principles of Biomedical Ethics. 6th ed. New York: Oxford University Press; 2009.
35. Frankfurt HG. On Bullshit. Princeton: Princeton University Press; 2005.
36. Tucker Edmonds B, Torke AM, Helft P, Wocial LD. Doctor, what would you do? An answer for patients requesting advice about value-laden decisions. Pediatrics. 2015;136(4):740–5.
37. Kaufmann W. Critique of Religion and Philosophy. Garden City: Anchor Books; 1961.
38. Moore GP, Lemyre B, Daboval T, Ding S, Dunn S, Akiki S, et al. Field testing of decision coaching with a decision aid for parents facing extreme prematurity. J Perinatol. 2017;37(6):728-34. doi:10.1038/jp.2017.29.
39. Staub K, Baardsnes J, Hébert N, Hébert M, Newell S, Pearce R. Our child is not just a gestational age: a first-hand account of what parents want and need to know before premature birth. Acta Paediatr. 2014;103(10):1035-8. doi:10.1111/apa.12716. PubMed
40. Zaretsky R. The Subversive Simone Weil. Chicago: University of Chicago Press; 2021.
41. Paris JJ, Cummings BM, Moore MP. Compassion and mercy are not helpful in resolving intractable family-physician conflicts of interest on end-of-life care. J Perinatol. 2019;39:11–7.
42. De Proost L, Verweij EJT, Ismaili M’hamdi H, et al. The edge of perinatal viability: understanding the Dutch position. Front Pediatr. 2021;9:634290.
43. Grady C. Enduring and emerging challenges of informed consent. N Engl J Med. 2015;372(9):855–62.
44. Silverman WA. Where’s the Evidence? Oxford: Oxford University Press; 1998.
45. McHaffie HE, Laing IA, Parker M, McMillan J. Deciding for imperiled newborns: medical authority or parental autonomy? J Med Ethics. 2001;27(2):104–9.
46. Guillen U, Suh S, Munson D, et al. Development and pretesting of a decision-aid to use when counseling parents facing imminent extreme premature delivery. J Pediatr. 2012;160(3):382–7.
47. Veatch RM. Implied, presumed, and waived consent: the relative moral wrongs of under- and over-informing. Am J Bioeth. 2007;7(12):39–41.
48. Kaempf JW, Guillen UG, Litt JS, Zupancic JAF, Kirpalani H. Change in neu- rodevelopmental outcomes for extremely premature infants over time: a systematic review and meta-analysis. Arch Dis Childhood Fetal Neonatal Edn. 2022. https://doi.org/10.1136/archdischild-2022-324457.
49. Ni Y, O’Reilly H, Johnson S, Marlow N, Wolke D. Health related quality of life from adolescence to adulthood following extremely preterm birth. J Pediatr. 2021;237:227–36.
50. Batsvik B, Vederhus BJ, Halvorsen T, Wentzel-Larsen T, Graue M, Markestad T. Health-related quality of life may deteriorate from adolescence to young adulthood after extremely preterm birth. Acta Paediatr. 2015;104:948–55.
51. Gire C, Resseguier N, Brévaut-Malaty V, Marret S, Cambonie G, Souksi-Medioni I, et al. Quality of life of extremely preterm school-age children without major handicap: a cross-sectional observational

study. Arch Dis Child. 2019;104(4):333-9. doi:10.1136/archdischild-2018-315046.

52. Saigal S, Ferro MA, Van Lieshout RJ, Schmidt LA, Morrison KM, Boyle MH. Health-related quality of life trajectories of extremely low birth weight survivors into adulthood. J Pediatr. 2016;179:68–73.
53. Rysavy MA, Li L, Bell EF, et al. Between-hospital variation in treatment and outcomes in extremely premature infants. N Engl J Med. 2015;372(19):1801–11.
54. Watkins PL, Dagle JM, Bell EF, Colaizy TT. Outcomes at 18 to 22 months of corrected age for infants born at 22 to 25 weeks of gestation in a center practicing active management. J Pediatr. 2020;217:52-58.e1.
55. Harris LH. Divisions, new and old—conscience and religious freedom at HHS. N Engl J Med. 2018;378(15):1369–71.
56. Cavolo A, de Casterle BD, Naulaers G, Gastmans C. Physicians' attitudes on resuscitation of extremely premature infants: a systematic review. Pediatrics. 2019;143(6): e20183972.
57. Wilkinson D. Sleep softly: Schubert, ethics and the value of dying well. J Med Ethics. 2020;47(4):218–24.
58. McGee A. Moral status of babies. J Med Ethics. 2013;39:345–8.
59. Rawlins MD. Cost, effectiveness, and value: how to judge? J Am Med Assoc. 2016;316(14):1447–8.
60. Chua KP, Conti RM, Freed GL. Appropriately framing child health care spending: a prerequisite for value improvement. J Am Med Assoc. 2018;319(11):1087–8.
61. Ord T. The moral imperative toward cost-effectiveness in global health. Center for Global Development. March 2013. Accessed Sept 2021. www. cgdev.org/content/publications/detail/1427016.
62. Beam AL, Fried I, Palmer N, Agniel D, Brat G, Fox K, et al. Estimates of healthcare spending for preterm and low-birthweight infants in a commercially insured population: 2008-2016. J Perinatol. 2020;40(7):1091-9. doi:10.1038/s41372-020-0635-z.
63. Hay S, Mowitz M, Dukhovny D, Viner C, Levin J, King B, et al. Unbiasing costs? An appraisal of economic assessment alongside randomized trials in neonatology. Semin Perinatol. 2021;45(3):151391. doi:10.1016/j.semperi.2021.151391.
64. Helgesson G. It is not ethical to save an infant's life just because we can, without due regard to outcome. Acta Paediatr. 2017;107(2):194–5.
65. Lonnqvist P. Number needed to suffer: replying to comments on my paper. Acta Paediatr. 2018;107:204–5.
66. Waitzman NJ, Jalali A, Grosse SD. Preterm birth lifetime costs in the United States in 2016: an update. Semin Perinatol. 2021;45: 151390.
67. Statistics Canada. Table 13-10–0713-01. Infant deaths and mortality rates, by age group. Accessed Sept 2021. https://doi.org/10.25318/13100 71301-eng.
68. Lannon SM, Guthrie KA, Vanderhoeven JP, Gammill HS. Uterine rupture after periviable cesarean delivery. Obstet Gynecol. 2015;125:1095–100.
69. Blanc J, Resseguier N, Goffinet F, Lorthe E, Kayem G, Delorme P, et al. Association between gestational age and severe maternal morbidity and mortality of preterm cesarean delivery: a population-based cohort study. Am J Obstet Gynecol. 2019;220(4):399.9. doi:10.1016/j.ajog.2019.01.005
70. Jarde A, Feng YY, Viaje KA, Shah PS, McDonald SD. Vaginal birth vs caesarean section for extremely preterm vertex infants: a systematic review and meta-analyses. Arch Gynecol Obstet. 2020;301(2):447–58.
71. Cummings JA. Antenatal counseling regarding resuscitation and intensive care before 25 weeks gestation. Committee on fetus and newborn clinical report. Pediatrics. 2015;136(3):588–95.
72. Midgley M. The Essential Mary Midgley. In: David Midgley editors. New York: Routledge; 2005.
73. Kaplan A. The new world of philosophy. New York: Vintage Books; 1961.
74. Lucey JF, Rowan CA, Shiono P, Wilkinson AR, Kilpatrick S, Payne NR, et al. Fetal infants: the fate of 4172 infants with birth weights of 401 to 500 grams – the Vermont Oxford Network experience (1996–2000). Pediatrics. 2004;113(6):1559–66. doi:10.1542/peds.113.6.1559.
75. Janvier A, Lantos J. Delivery room practices for extremely preterm infants: the harms of the gestational age label. Arch Dis Childhood Fetal Neonatal Edn. 2016;101(5):F375-376.
76. Kaempf JW, Tomlinson MW, Tuohey J. Extremely premature birth and the choice of neonatal intensive

care versus palliative comfort care: an 18-year single center experience. J Perinatol. 2016;36:190–5.
77. Muller HJ. The uses of the past: profiles of former societies. New York: Oxford University Press; 1952.
78. Corngold S. Walter Kauffmann: Philosopher, Humanist, Heretic. Princeton: Princeton University Press; 2019.
79. Cioran EM. The temptation to exist. New York: Arcade Publishing; 1956.
80. Lau T, Tao Te Ching, Lau DC. Translator. London: Penguin Books; 1963.