Fetal Needs, Physicians' Duties

by Susan S. Mattingly

Introduction

With advances in prenatal diagnostic and intervention techniques, judgments that fetal needs require prompt medical or surgical attention are rapidly becoming more accurate and more common. Fetal therapies offer remarkable new opportunities to improve reproductive outcomes, but in some instances they are resisted. I will explore ethical questions raised for physicians by maternal refusals of recommended fetal treatment. Based on duties defined by the familiar medical ethical principles of benefit, autonomy, and justice, how *should* physicians respond when pregnant women refuse treatment recommended for the fetus? Specifically, may physicians seek to compel treatment? Should they? To clarify physicians' duties, a side trip into maternal ethics will be necessary.

My explorations are limited in a number of ways. Attention is restricted to cases in which the fetus is highly developed, where it is plausible to consider the fetus as a second patient to whom independent obligations are owed. This is a disputed point but I skip over it to ask, *If* physicians have both fetal and maternal duties, what precisely are they and what are their relative stringencies? Excluded are cases in which prenatal treatment is recommended to correct or alleviate fetal defect or disease resulting from medical or maternal fault. I want to be able to discuss obligations to the fetus pure and simple, not compounded by duties to remedy harms caused deliberately or by neglect. Thus, cases involving drug-induced fetal distress and the like are omitted. Also excluded are treatments recommended for maternal as well as fetal health, for my purpose is to delineate duties generated by fetal medical needs alone.

In considering the ethical propriety of compulsory fetal treatment, I do not venture into legal requirements and liabilities. Only by keeping legal and ethical questions distinct can we know whether physicians' legal responsibilities are supportive of or inimical to their ethical responsibilities, hence whether or not laws *ought* to be changed. Finally, although a complete account of any complex ethical issue requires that theoretical considerations be fleshed out with contextual richness drawn from particular cases, my intent here is confined to revealing the bare bones of applicable principles and their relationships one to another.

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The Physician's Dilemma

Most maternal refusals of fetal treatment should not be considered ethically problematic by physicians. Many of these procedures are still experimental, hence they are ethically optional. Treatment is likewise optional when anticipated fetal benefits are marginal or of low probability or when fetal or maternal burdens and risks are substantial. "Weighing" the magnitude and likelihood of medical benefits and burdens is not a scientific procedure but a matter of judgment based on uncertainties and value assumptions. How much weight should be assigned, for instance, to the benefit of life in relation to the burdens of severe and incorrectable health deficits? Maternal estimates may differ from physicians' yet be reasonable and ethically unexceptional.

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But let us suppose a range of cases in which, on any reasonable interpretation, prospective medical benefits to the fetus are substantial and medical burdens to both fetus and pregnant woman are relatively small. Based on proportionality of benefits to burdens, treatment seems clearly to be indicated. Maternal refusals of fetal treatment under this assumption create an ethical dilemma for physicians.

When a parent refuses medical treatment clearly necessary for the life or health of an infant or child, the physician's duty to respect parental refusal is outweighed by the duty to ensure that the child's basic medical needs are met. In such circumstances, benefit "trumps" autonomy (borrowing Dworkin's useful metaphor).[1] Alternatively, when a (nonpregnant) woman refuses medical treatment for herself, the physician's duty to respect her competent refusal outweighs the duty to provide care. This time, autonomy trumps benefit. It is the fact of pregnancy which creates for the physician an ethical conundrum: one patient in need of treatment nested within another patient who refuses it. The woman's autonomy constrains the physician's duty of benefit to her, not to anyone else; if maternal autonomy is respected, fetal benefit is infringed. On the other hand, treating the fetus without maternal consent involves performing a medical procedure against her will; if fetal benefit is provided, maternal autonomy is infringed. Either way, a significant duty to one of two patients is infringed without evident justification. Which duty should take precedence: fetal benefit or maternal autonomy?

Maternal Refusals as Proxy Choices

Before exploring the physician's competing duties further, consider the ethics of treatment decisions from the maternal perspective. I assume without argument that in advanced pregnancy, beyond the point where elective abortion is appropriate, the woman has by design or default acquired maternal obligations to act as moral fiduciary for the fetus.[2] How are these obligations to be met?

Valid Proxy Choices

One way is by consenting to medically-indicated prenatal treatment. But maternal duties are not and should not be restricted to the medical perspective. First, fetal *health* is a broader and more appropriate maternal goal than fetal *medical benefit*. If a woman has purchasing power for medicine or adequate nutrition, but not both, it is not clear that the former is the better choice for fetal health. Nor are maternal responsibilities for the fetus limited to immediate health needs. Mothers are, or should be, concerned to provide conditions for their offspring's *global well-being*, a concept which encompasses physical and mental health and other essential goods and which may require tradeoffs between present and future. Extended medical treatments may jeop-

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ardize a pregnant woman's job and hence her plans to move out of a high-crime neighborhood. Which option is better for fetal and child well-being? It is not invariably true that medically-indicated treatment optimizes patient health and long term well-being; *best medical interests* and *best interests* are not one and the same, nor do the former always serve the latter. Even when medical treatment is a necessary condition for patient health, limited resources may force choices between necessities, and among necessities medical treatment does not always rank first.

While physicians are obligated by medical ethics to make recommendations in terms of the patient's best medical interests (that being their area of expertise), patients and proxies for patients are obligated by general and family ethics to assess these recommendations in terms of the patient's best interests more broadly construed. In terms of parental ethics, it is permissible, even obligatory, to refuse for a child recommended medical or surgical interventions which, in the real world of available alternatives, detract from or are less likely than some different approach to promote the child's global best interests. Thus, maternal refusal of medically-indicated fetal treatment may be contrary to the fetus's best medical interests yet be a valid proxy choice, consistent with the maternal duty to protect and promote the health and global well-being of the fetus and child-to-be.

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Not only is the pregnant woman morally obligated to balance medical against nonmedical fetal needs, she is obligated by her family role to balance fetal needs against needs of other family members to whom she is responsible. Hospitalization to diminish risks of premature delivery may be advised, yet the woman's absence from the home may place at risk young children or an ill parent for whom there is no alternative caregiver. As moral fiduciary for mulitple dependents, the woman must try simultaneously to guard each dependent's *fair share* of well-being within the family.[3] To assert that she ought to do *more* for the fetus entails, falsely, that she ought to do *less* for other dependents or that she *can* do more for all.

From the physician's perspective, a maternal proxy choice based on total family needs is tainted by conflict of interest. The physician's concern is exclusively for the fetus, since the fetus is the patient and other family dependents are not.[4] It is unethical for physicians to formulate medical recommendations by balancing patient medical needs against needs of nonpatients. From the maternal perspective, a physician's judgment based on fetal needs alone is tainted by moral tunnel vision. Needs and interests *do* conflict, and her moral role requires that she accommodate them all as best she can. So, again, maternal refusal of medically-indicated fetal treatment may be contrary to the fetus's best medical interests, even contrary to fetal health and global well-being, yet be a valid proxy choice, consistent with the maternal duty to protect and promote the fetus's fair share of well-being within the family.

Pregnant women and physicians operate in moral spheres which overlap but have different boundaries; factors extraneous to the making of ethical *medical* recommendations are central to ethical *maternal* review of those recommendations. When maternal refusal of recommended fetal therapy is a valid proxy choice justified in terms of maternal obligations, the physician's duty to respect the autonomy of the maternal proxy correctly takes precedence over the duty of medical benefit to the fetus. Medical values are properly constrained by the more encompassing values of family and general ethics, not *vice versa*.

Better than acquiescence in a valid maternal refusal is action to ameliorate conditions of scarcity, if that is what makes refusal in specific circumstances reasonable and ethical. Fetal needs require that obstacles to consent be explored. Physicians are ill-equipped by personal experience or professional training to communicate empathically across boundaries of gender, age, socioeconomic class, and ethnicity, but such communication is necessary if extramedical factors impeding maternal consent are to be identified and, perhaps, changed. By securing access for the woman and her family to sources of nonmedical support—nutrition programs, financial assistance, volunteer transportation services, respite caregivers—the physician may *enable* her to consent to recommended fetal therapy. This should be the physician's goal.

Invalid Proxy Choices

For reasons mentioned in the preceding section, physicians should be cautious in concluding that, in a particular instance, maternal refusal of medically-indicated fetal treatment is morally irresponsible. Still, it would be naive to suppose that such a judgment is never warranted. It is surely the case that women sometimes refuse prenatal treatment without justification of conflicting obligations, that some maternal refusals as proxy choices are morally wrong. In such cases, the moral weight which previously favored autonomy of maternal proxy over fetal medical benefit is removed; now, fetal benefit trumps autonomy of (invalid) maternal proxy. Are physicians morally permitted or obligated in such circumstances to seek to compel fetal treatment?

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It might seem that priority of benefit justifies compulsory treatment straightaway, but that is not the case. If A wrongly withholds benefit x from B, third party C may or may not be morally justified in seeking coercively to provide x to B. Intervention may make matters worse or simply be ineffective; C may have no moral standing to intervene or may have more urgent conflicting duties. Physicians contemplating requests for court-ordered fetal therapy need to consider the immediate and long-term damage of forced treatment to the mother-child relationship, as well as health losses if other women, fearing forced treatment, defer prenatal medical care. Effectiveness of alternative ways to promote perinatal health (not in this case but in the aggregate) might be considered. I set aside consequentialist considerations such as these and return the focus to physicians' duties: Is there any ethical duty binding on physicians which prohibits coercive intervention when maternal proxy consent to fetal therapy is wrongly withheld?

Maternal Refusals as Patient Choices

If a woman's refusal of fetal therapy were nothing but a proxy refusal on behalf of the fetus, invalidity of that choice would create at least a *prima facie* case for compulsory treatment, as do invalid parental refusals of medically necessary treatment for infants and children. However, refusal of therapy for the fetus is also a choice in a different category. Inextricably, treating the fetal patient involves treating the maternal patient as well. The surgical incisions, the injections, the oral medications are administered to the pregnant woman and through her to the fetus. Thus, unlike parental choice for a child, the woman's proxy

choice for the fetus is also a *patient* choice: she refuses treatment of herself on her own behalf. How should the physician weigh fetal benefit in relation to autonomy of the pregnant woman *qua* patient?

The duty to respect patient autonomy may be overridden by the duty of benefit under a variey of conditions: If the patient is incompetent, for instance, or if harm to others is caused by treatment refusal.

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Where conditions such as these apply, they justify medical paternalism: treatment of patients against their will for their own good. Patient autonomy is overridden by patient benefit. But conditions justifying medical paternalism are inapplicable to the problem of maternal autonomy versus *fetal* benefit. The fetal therapies we are considering are, by hypothesis, of no medical benefit to the pregnant woman yet subject her to (relatively small) burdens and risks. Fetal treatment is nontherapeutic to the maternal patient. Constraining the maternal patient's autonomy to treat her nontherapeutically cannot be justified as medical paternalism. She is treated against her will, *contrary* to her own good, for the good of the fetus.

To speak of autonomous refusal in the context of nontherapeutic treatment is logically odd. What we have in relation to *therapeutic* treatment (if we are competent and thereby cause no undue harm to others) is a right of autonomous refusal. What we have in relation to *nontherapeutic* treatment is something different and more fundamental: I will call it an *immunity against medical harm.* This immunity is definitive of the medical enterprise. "First, do no harm; undertake no medical treatment of a patient without therapeutic intent for that patient." The physician duty corresponding to this basic injunction, *nonmaleficence*, is simply the negative component of the duty of benefit (as distinguished from the positive component, *beneficence*, the duty to help, to treat therapeutically). Autonomous refusal of nontherapeutic treatment, if not superfluous, is at any rate secondary, an ethical backup against treatment which is itself unethical. When fetal treatment is nontherapeutic to the maternal patient, the patient duty vying for priority with fetal benefit is not *maternal autonomy* at all; it is *maternal nonmaleficence.*

The physician's duty of nonmaleficence is not absolute, for immunity against nontherapeutic treatment may be voluntarily waived, as when a person volunteers to be a subject of nontherapeutic research or when a person submits to surgical removal of healthy tissue to aid a seriously ill family member. But in the absence of autonomous waiver of immunity against medical harm, there is no basis in theoretical medical ethics and no precedent in unambiguously ethical medical practice for nontherapeutic treatment of one patient to obtain therapeutic benefits for another. Medical harms and risks to a patient are justified only by medical benefits *to that patient.* Utilitarian tradeoffs of harm for good *between* patients are repudiated by the medical ethical conception of justice. Inherent in the patient role is an immunity against physician-inflicted harm which cannot be overcome even by large benefits to many others. If you need an appendectomy, do you hesitate for fear that, once under anaesthesia, your heart, liver, lungs, and kidneys might be removed to save the lives of six others? Not unless you fear that you are in the hands of unethical physicians. Nonmaleficence (to one) trumps beneficence (to another, or six others, or indefinitely more).[5]

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Fetal medicine might well look to tissue transplantation as an ethical model. Here, concepts of benefit, autonomy and justice have been explicitly applied to cases in which physicians simultaneously owe duties to two patients in symbiotic relationship, a relationship analogous in many respects to the maternal-fetal dyad.[6] In transplantation, as in fetal medicine, one patient is treated nontherapeutically in order to obtain therapeutic benefits for another; medical harms to the first are small in relation to medical gains for the second (kidney donation involves discomforts and risks of the same order as caesarean delivery); the first patient may have parental obligations to the second; there may be no effective alternative therapies.

Parental refusal to provide the needed gift of tissue in the absence of extenuating circumstances would certainly appear to be a despicable violation of parental ethics. Yet there is no suggestion in the medical ethics literature that physicians may or should seek court orders to proceed with tissue transfer in such cases. To the contrary, the ethos of transplantation is highly protective of decisions not to donate, even when familial obligation is strong and opportunities for medical rescue are thereby lost.[7] Family pressure is regarded as "moral blackmail" to be neutralized lest it taint the autonomous quality of the donor's waiver against medical harm and cast doubt on the physician's moral liberty to infringe that fundamental taboo.

The model of transplantation ethics cautions against the fiction that pregnancy itself constitutes consent to fetal therapy. The notion of presumed consent has never gained currency in American transplantation ethics, not even for cadaver tissue. And even if pregnancy were *prima facie* evidence of consent, such decisions are subject to reconsideration. Transplantation physicians are alert to signs of wavering donor commitment, and the possibility of retracting consent is held open until the last moment. If a pregnant woman who refuses fetal therapy is similiar to a kidney donor who reneges, it does not follow that the physician may or should disregard her second thoughts. By late pregnancy, of course, the woman has already made a substantial gift. In refusing medical treatment for the fetus she does not renege on the gift already made. Rather, she (rightly or wrongly) refuses to make an *additional* donation. She is like a kidney donor who (rightly or wrongly) declines when it turns out that a bit of liver is needed, too.

The stringent duty of nonmaleficence prohibits physicians from seeking to compel prenatal treatment for the sake of fetal benefits even if maternal refusal *qua* proxy choice appears to violate maternal obligations to the fetus. Nonmaleficence to the maternal patient outweighs beneficence to the fetal patient. This conclusion, derived from theoretical principles of medical ethics, is reinforced by the model of transplantation ethics; duties of beneficence to prospective tissue recipi-

ents are in fact subordinated by physicians to their duties of nonmaleficence to prospective donors, the latter's familial duties and the former's urgent medical needs notwithstanding. Again, fetal needs require that the woman's motives and concerns be explored before the physician accedes to maternal refusal. Involvement of supportive family members should not be ruled out. The goal should be to provide assistance to *enable* the woman to give consent, but the boundary separating encouragement and expectation from coercion should be observed. Where the means to fetal medical benefit is maternal medical harm, the physician's duty forbidding nontherapeutic treatment ethically overcomes the impulse toward fetal rescue.

Notes

1. Ronald Dworkin, Taking Rights Seriously (Cambridge, MA.: Harvard University Press, 1977), p. xi.

2. In making this assumption I gloss over a plethora of extenuating circumstances: barriers in our medical and social systems to timely abortion, for instance, or the woman's intention or post-delivery decision to release the infant for adoption. For these reasons among others, duties to a developed fetus should probably be considered *quasi-maternal*, stronger than a woman's moral duties to someone else's child (generic duties owed to strangers *qua* human) but weaker than a mother's moral duties to her child (true maternal duties).

3. I deliberately avoid the language of rights in this paper, but even if rights are attributed to the fetus, this does not alter the maternal duty to balance fetal claims against those of other dependents. An analogy makes this clear: Creditor has a right to be paid in full by Debtor, but in bankruptcy proceedings Creditor's claim must be balanced against claims of others whom Debtor owes according to priority rules for settlement among them. In such circumstances, Creditor's right guarantees not full but a fair-share payment.

4. In theory and training, family practice medicine is more sensitive to the need for accommodation between the traditional patient-centered medical perspective and the global perspective of the family. See Ronald J. Christie and C. Barry Hoffmaster, Ethical Issues in Family Medicine (New York: Oxford University Press, 1986).

5. The extreme difference in stringency between nonmaleficence and beneficence may, I think, be expressed in Kantian terms as the difference between *perfect* and *imperfect* duties. The physician's duty prohibiting nontherapeutic treatment is a perfect negative duty to be exercised constantly (awake and asleep, on duty and off) in relation to all persons (patients and nonpatients alike). The duty requiring therapeutic treatment is an imperfect positive duty owed to some persons (patients) at certain times and places, subject to all manner of nonethical and ethical conditions. Physicians are not always at liberty to exercise beneficence, but they are always to conform to requirements of nonmaleficence.

6. For a discussion of parallels between transplantation and pregnancy, see Susan S. Mattingly, "Viewing Abortion from the Perspective of Transplantaion: The Ethics of the Gift of Life," *Soundings*, 67 (1984), pp. 399-410.

7. See, for instance, the classic study by Roberta G. Simmons, *et al.*, Gift of Life: The Social and Psychological Impact of Organ Transplantation (New York: John Wiley and Sons, 1977). It seems to me that the transplantation ethos goes too far in trying to protect prospective donors from family moral expectations. It is not the physician's role to enforce familial duties, but neither should it be the physician's role to thwart the exercise of a family's moral authority.

The Rights of Pregnant Women

by Joan Mahoney

Not too long ago, the carrying and bearing of children took place surrounded by women. During childbirth, the women of a tribe, and, later midwives, were present and assisted the mother in the birth process. Only in the last century or so, and only in the industrialized West, has the birth process become a medical procedure. The use of hospitals and doctors became the norm; women became patients rather than participants. The development of anaesthethics made it possible for women to give birth while they were unconscious, so that they were unaware, rather than simply not in control, of what was happening to them.

In the last twenty years or so, women have begun to reassert control over the child-bearing process. The availability of contraceptives has allowed women the choice as to whether to become pregnant. After *Roe v. Wade*,[1] those who did become pregnant had the choice whether or not to continue the pregnancy. In addition, the popularity of prepared childbirth gave many women the opportunity to give birth without drugs, and new types of anaesthetics allowed pain relief without unconsciousness.

At the time these developments were occurring, medical advances were also enabling intervention to save the lives or improve the prospects for fetuses. While the rate of caesarean section has grown rather alarmingly in the United States, some of these operations have saved babies from death or serious damage. In recent years fetal surgery has been performed in instances where the fetus might otherwise have died.

These advances alone, however, do not account for the recent emphasis on the fetus as an entity separate from the mother. Certainly in those cases where a pregnant woman chooses a caesarean or prenatal surgery, the woman and her doctor can work together to do their best for her baby. But when medical care is imposed on a woman against her choice, or when she is threatened with jail or the loss of her child for what she is doing to her own body or because she has failed to follow her doctor's orders, then, rather

When medical care is imposed on a woman against her choice, or when she is threatened with jail or loss of her child for what she is doing to her own body or because she has failed to follow her doctor's orders, then, rather than a cooperative situation, mother and fetus are pitted against one another.

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