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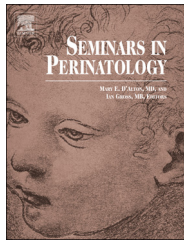

Ethical issues in periviable birth

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ABSTRACT

Ethics is an essential dimension of the management of periviable birth in both clinical practice and research. The goal of clinical care in periviable birth is to improve outcomes for current pregnant and fetal patients. The goal of research in periviable birth is to improve outcomes for future pregnant patients and fetal patients. This paper provides an ethical framework for professionally responsible clinical management and research to improve the outcomes of periviable birth. The ethical framework is based on the professional responsibility model of obstetric ethics, which rejects rights-based reductionism. This model elaborates the ethical concept of the fetus as a patient in terms of beneficence-based and autonomy-based obligations to the pregnant woman and beneficence-based obligations to the fetus and emphasizes that the fetus is not a separate patient. Guidance is provided for counseling pregnant women about the management of pregnancies at 22 weeks of well-documented gestation, for which directive counseling in the form recommending non-aggressive obstetric management is ethically justified. At 24 weeks and later of gestation, directive counseling in the form of recommending aggressive obstetric management is ethically justified. For the period between 22 and 24 weeks gestation, non-directive counseling is ethically justified. Guidance is also provided for counseling pregnant women about participation in clinical trials and in innovative intervention for fetal benefit. Non-directive counseling should be strictly followed for both.

1. Introduction

Ethics is an essential dimension of the management of periviable birth in both clinical practice and research. The goal of clinical care in periviable birth is to improve outcomes for currently pregnant patients and fetal patients. The goal of research in periviable birth is to improve outcomes for future pregnant and fetal patients. The purpose of this paper is to provide an ethical framework for professionally responsible clinical management and research to improve the outcomes of periviable birth.

2. Ethical concepts and reasoning

Three ethical principles ground and direct professionally responsible patient care and research.[1,2] The first is the ethical principle of beneficence. This is the oldest ethical principle in the history of Western medical ethics. The earliest known version is the injunction in the Hippocratic Oath to benefit the sick while keeping them from harm and injustice.[3] One of the first uses of "beneficence" in the subsequent history of Western medical ethics occurred in Thomas Percival's (1740–1804) *Medical Ethics*, the first book

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with that title in the global history of medical ethics.[4] Percival used this word the way it is used in contemporary medical ethics: The physician is obligated to provide clinical management that, in deliberative (evidence-based, rigorous, and accountable) clinical judgment, is reliably expected to result in a greater balance of clinical good over clinical harm for the patient. Technically possible clinical management that is supported in beneficence-based clinical judgment is known as "medically reasonable."

The second ethical principle, respect for the patient's autonomy, has its origins in seventh-century British surgery.[5] Surgeons at that time provided their services on the basis of contracts. Making contracts, then and now, requires the contractor of services to provide information about them and obtain consent. A more sophisticated process of what came in the twentieth century to be called informed consent was practiced by the Brooklyn gynecologist, Alexander Skene (1837–1900).[6] Dr. Skene provided his female patients with information about their gynecological diseases, explained the need for surgery, and obtained consent. When women refused, he provided medical management and engaged women in discussion aimed at reconsideration of their refusal. In the twentieth century, the ethical principle of respect for autonomy was articulated: The physician is obligated to empower the pregnant woman's autonomy by providing her with information about her diagnosis, the medically reasonable alternatives for the clinical management of her diagnosis, and the clinical benefits and risks of each medically reasonable alternative.

The third ethical principle is justice. In its most general formulation, this ethical principle requires that like cases be treated alike by seeing to it that all individuals similarly situated receive what is due to them.[2] Of the accounts in the history of moral and political philosophy of what "due" should mean, the concept of exploitation is relevant here. Exploitation occurs in a population of patients when a small percent experience, as the outcome of clinical care, significant benefit with little or no clinical harm but a much a larger percent experience significant clinical harm—such as death and serious disability—without the opportunity to experience offsetting clinical benefit.

The perinatologist's obligations to pregnant patients and fetal patients should be based on the professional responsibility model of obstetric ethics.[7] This model serves as an antidote to the fallacy of rights-based reductionism. Rights-based reductionism is a subset of ethical reductionism. Ethical reductionism occurs when ethical reasoning appeals *exclusively* to one ethical concept in clinical circumstances that by their very nature require consideration of multiple, complementary concepts if those circumstances are to be adequately understood and responsibly managed. Rights-based reductionism commits the fallacy of reasoning about ethical issues in perinatal medicine on the basis of exclusively the rights of the fetus or the rights of the pregnant woman.

Fetal rights-based reductionism occurs when reasoning about ethical issues in obstetrics appeals only to the rights of the fetus. On such accounts, the rights of the fetus become the controlling source of the perinatologist's obligations in patient care at all gestational ages. The pregnant woman's rights become systematically secondary. Fetal rights-based reductionism would support the primacy of any fetal interest at the expense of the pregnant woman's autonomy and regardless of adverse clinical outcomes for her.

Pregnant-woman rights-based reductionism occurs when reasoning about ethical issues in obstetrics appeals only to the rights of the pregnant woman. The woman's right to control her body overrides fetal rights at all gestational ages. Fetal rights become systematically secondary to the pregnant woman's rights. Pregnant-woman rights-based reductionism would support the pregnant woman's preferences regardless of adverse clinical outcomes for the fetal or neonatal patient.

The result of rights-based reductionism in obstetric ethics is a clinical and ethical disaster. At first blush, rights-based reductionism offers an appealing simplicity: identify the right at stake and provide clinical management that implements the right. On closer examination however, rights-based reductionism is ethically incomplete because it ignores altogether or unjustifiably discounts beneficence-based obligations to *both* the pregnant and fetal patients. The result is to distort the integrity of clinical judgment beyond recognition and reduce the perinatologist to a mere technician. In our view therefore, rights-based reductionism is unprofessional and has no legitimate place in obstetric ethics. The rights of women play an important role in perinatal ethics but not an exclusive role.

The authors have argued elsewhere that obstetric ethics should be based on the ethical concept of medicine as a profession.[1,7] This concept was introduced into the global history of medical ethics by two remarkable physician–ethicists, John Gregory (1772–1773) of Scotland and Thomas Percival of England. The concept has three components: (1) the physician should become and remain scientifically and clinically competent, engaging in the deliberative practice of medicine and clinical research; (2) the physician should protect and promote the health-related and other interests of the patient as the physician's primary concern and motivation, keeping self-interest systematically secondary; and (3) physicians should not regard medicine as a merchant guild (which it had been for centuries) but as a "public trust" (Percival's phrase) that exists for the benefit of present patients and should be improved for the benefit of future patients.[8]

Professional responsibility in obstetric patient care and research is based on the ethical principles of beneficence and respect for autonomy. The obstetrician has beneficence-based obligations and autonomy-based obligations to the pregnant patient and beneficence-based obligations to the fetal patient. All three sets of obligations must be taken into account and balanced against each other in deliberative clinical judgment. We emphasize that that the fetal patient is not a separate patient, in the sense that obligations to the fetal patient are the whole of the ethical story. Our position explicitly rejects such an account, which is both clinically and ethically inadequate.

When the fetus is a patient and the evidence for obstetric management for fetal and neonatal benefit is reliable, counseling of the pregnant woman is justifiably directive. The nature of such clinical management as medically reasonable should be explained and the obstetrician should then recommend it. When the evidence is weak or non-reliable, the nature of such clinical management as medically reasonable should be explained and then the obstetrician should offer but not recommend it.