Seminars in Fetal & Neonatal Medicine 20 (2015) 364–367

Contents lists available at ScienceDirect

Seminars in Fetal & Neonatal Medicine

journal homepage: www.elsevier.com/locate/siny

Review

Ethics in perinatal medicine: A global perspective

Frank A. Chervenak [a, *], Laurence B. McCullough [b]

[a] Department of Obstetrics and Gynecology, Weill Medical College of Cornell University, New York, NY, USA
[b] Center for Medical Ethics and Health Policy, Baylor College of Medicine, Houston, TX, USA

Keywords:
Autonomy
Beneficence
Healthcare justice
Professional responsibility
Perinatal ethics

SUMMARY

This article describes the professional responsibility model of perinatal ethics, which requires the perinatologist in all cases to identify and balance beneficence-based and autonomy-based obligations to the pregnant patient, beneficence-based obligations to the fetal patient, and beneficence-based obligations to the neonatal patient. We explain how this model avoids the clinical failure of both fetal and maternal rights-based reductionism, i.e., insistence either on unlimited fetal rights or on unlimited maternal rights, respectively. The professional responsibility model of perinatal ethics provides the basis for the transnational clinical ethical concept of healthcare justice, which requires that beneficence-based obligations to all patients be routinely fulfilled by providing them with an evidence-based standard of care. We then show how healthcare justice can be used to identify and address ethically unacceptable allocation of healthcare resources. The professional responsibility model of perinatal ethics creates an important role for the perinatologist as responsible advocate for pregnant, fetal, and neonatal patients.

1. Introduction

Perinatal medicine has become a global medical discipline that combines obstetrics and pediatrics. Like all medical disciplines, the clinical practice of perinatal medicine should be guided by an ethical framework. In this paper we present such a framework – the professional responsibility model of perinatal ethics [1] – and identify its implications for the global specialty of perinatal medicine.

2. The professional responsibility model of perinatal ethics

The professional responsibility model of perinatal ethics provides a transnational, transcultural, and transreligious ethical framework that should guide perinatologists in responsibly caring for pregnant, fetal, and neonatal patients. We base this ethical framework on what we have called the professional responsibility model of obstetric ethics [2,3].

The clinical ethical significance of the professional responsibility model of perinatal ethics is that it is more clinically and ethically adequate than its two alternatives, both of which are forms of rights-based reductionism. Unacceptable clinical simplification of perinatal ethics occurs when the overriding ethical consideration is either the rights of the pregnant woman or the rights of the fetus.

2.1. Rights-based reductionism

We begin by describing and providing a critical appraisal of fetal rights-based reductionism [1,4] and maternal rights-based reductionism [1,5,6]. The abortion controversy vividly illustrates the main features of fetal rights-based reductionism. It holds that fetal rights always override the rights of the pregnant woman. Termination of pregnancy at any gestational age is ethically impermissible, for any reason and independently of whether the pregnancy is voluntary or not, or whether it is viable. By contrast, maternal rights-based reductionism holds that the pregnant woman's rights always override fetal rights. Termination of pregnancy is ethically permissible at any gestational age and for any or many reasons.

Both forms of rights-based reductionism are appealing because of the simple two-step reasoning that is invoked: (a) one either has rights or one does not; (b), if one does have rights, others must always respect and implement them. This simple dichotomy does not withstand clinical ethical appraisal. This is because of a fundamental, unsolvable philosophical problem: there is deep, centuries-old controversy about the nature and limits of both the fetus's and the pregnant woman's rights [7]. Rights are based on many factors, including cultural, political, and religious beliefs that

* Corresponding author. Address: New York Presbyterian Hospital, 525 East 68th Street, M-724, Box 122, New York, NY 10021, USA. Tel.: +1 (212) 746 3184; fax: +1 (212) 746 8727.
E-mail address: fac2001@med.cornell.edu (F.A. Chervenak).

http://dx.doi.org/10.1016/j.siny.2015.05.003
1744-165X/

do not lend themselves to compromise, which is the source of the endless controversy about them. Endless philosophical controversies are of no clinical value [1,2].

For example, consider the view of maternal rights-based reductionism: the pregnant woman has an unconditional right to control what happens to her body. The claim asserts that this has no limits or exceptions throughout the entire pregnancy. The reductionist view simply ignored that professional integrity sets justified limits on the preferences of patients [8,9], pregnant patients included. A distraught woman who is 34 weeks pregnant states that her partner has deserted her and requests induced abortion as soon as it can be scheduled. Professional integrity requires the perinatologist not to implement this request because feticide is ruled out by the perinatologist's beneficence-based obligation to protect the life of this fetal patient. The obstetrician should therefore recommend against feticide and explain that a conscientious obstetrician who takes seriously the professional responsibility to both the pregnant and fetal patient should not implement the request. This is but one clinical circumstance in which a pregnant woman's request for an induced abortion should not be implemented unquestioningly [10].

There are further problems with fetal rights-based reductionism, which holds that the fetus has an unconditional right to life or to complete gestation. The presence of a fetal anomaly incompatible with life exposes this view as lacking scientific and clinical foundation. The hard clinical reality is that perinatal medicine has no capacity to correct such anomalies. To insist on an unconditional right to life or to complete gestation proposes a clinically unrealistic ethical framework for perinatal practice.

Rights-based reductionism in both of its forms has no place in perinatal clinical practice, because both forms unacceptably ignore the professional nature of the relationship of every perinatologist to pregnant, fetal, and neonatal patients. The professional responsibility model of perinatal ethics avoids this unacceptable outcome.

2.2. The professional responsibility model

The professional responsibility model of perinatal ethics has its basis in the ethical concept of medicine as a profession, which enters the history of medicine in the eighteenth century. The concept was invented by the two giants of modern medical ethics: Dr John Gregory (1724–1773) of Scotland and Dr Thomas Percival (1740–1804) of England [1].

Gregory and Percival argued that this concept obligates the physician to make three commitments: (1) to become and remain scientifically and clinically competent; (2) to protect and promote the health-related and other interests of the patient as the physician's primary concern and motivation; and (3) to preserve and strengthen medicine as what Percival called a "public trust." By this phrase, Percival meant that medicine should no longer consider itself a merchant guild that exists primarily for the benefit of its members but instead as a social institution that exists primarily for the benefit of patients and society [1,11].

The professional responsibility model of perinatal ethics provides an ethical framework based on the perinatologist's beneficence-based an autonomy-based obligations to the pregnant patient and beneficence-based obligations to the fetal and neonatal patient [1]. The beneficence-based obligation of the perinatologist is to make evidence-based clinical judgments about diagnostic and therapeutic measures that are reliably expected to result in a greater balance of clinical goods over clinical harms for the pregnant, fetal, and neonatal patients. The perinatologist then empowers the pregnant woman's autonomy by offering or recommending clinical management of her pregnancy based on these obligations and the autonomy of parents by offering and recommending neonatal management based on these obligations.

The inadequacy of rights-based reductionism in both its forms can now be more precisely stated. Fetal rights reductionism has no place in perinatal ethics and practice because this approach inevitably leads perinatal ethics into conceptual and clinical failure. This approach should therefore be abandoned. Maternal rights reductionism is a failure also, because it requires the perinatologist to implement birth plans that unconditionally exclude cesarean delivery or the unconditional right to planned home birth [12]. This approach ignores the perinatologist's beneficence-based obligations to both the pregnant and fetal patients, resulting in the perinatologist becoming a mere technician, indeed automaton, and no longer a professional physician. This model also has obviously unacceptable implications, e.g. ruling out, as unwarranted intrusion, the pregnant woman's right to control what happens to her body by strongly and repeatedly recommending that pregnant women who abuse tobacco and alcohol seek help and be supported in doing so. Respect for the pregnant woman's rights allows simply accepting such clinical choices by patients because they have made clinically unwise, but autonomous, choices. This is not professional respect for the pregnant woman but abandonment of her from the perspective of the professional responsibility model. The maternal rights reductionism approach has no place in perinatal ethics because it also leads perinatal ethics to conceptual and clinical failure. This approach to perinatal ethics should therefore also be abandoned.

The professional responsibility model of perinatal ethics includes the pregnant woman's right to control her body but also, unlike the maternal rights-based reductionist approach, includes limits on these rights originating in the pregnant woman's beneficence-based obligations to the fetal patient and in the perinatologist's beneficence-based obligations to the fetal patient. The professional responsibility model of perinatal ethics also includes ethical obligations to the fetal patient. A major advantage of the model is that it explains these obligations without appeal to the vexing and divisive discourse of fetal rights and replaces this discourse with the clinically applicable concept of beneficence-based obligations to the fetal patient. In summary, unlike the two rights-based reductionist approaches, the professional responsibility model of perinatal ethics insists that, in all clinical circumstances, the perinatologist should identify and balance beneficence-based obligations to the fetal patient with beneficence-based and autonomy-based obligations to the pregnant patient [1].

3. Implications for global perinatology

Perinatal mortality and morbidity, especially in developing countries, pose a paramount challenge to global perinatology [13,14]. Ethics is an essential dimension of responsibly addressing these challenges. The professional responsibility model of perinatal ethics provides the basis for doing so: healthcare justice.

Justice is an ethical principle, originating in ancient Greek philosophy: cases should be treated alike by determining what is due to each stakeholder. In this formulation the concept of what is "due" to each individual is rather abstract. The task of perinatal ethics is to specify what is due to the stakeholders – pregnant, fetal, and neonatal patients – on the basis of beneficence-based and autonomy-based obligations to the pregnant patients, beneficence-based obligations to the fetal patient, and beneficence-based obligations to the neonatal patient. This is known as healthcare justice [15]. We identify challenges to healthcare justice in the allocation of healthcare resources to these patients and show how the