Drawing Moral Lines in Fetal Therapy

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Drawing moral lines, however difficult, is a significant part of the handiwork of ethics. Line drawing involves argumentation about why a particular limit should be respected from a moral point of view (i.e., a view that attempts to take the best interests of all into account in approaching the danger and promise of socio-moral problems). The goal of line drawing is to distinguish between permissible and impermissible acts or practices. The task proceeds best by analysis of cases in which one can distinguish tolerable from intolerable behavior and separate desirable from undesirable consequences. The line is presumably ready in theory, but the cases help to illustrate its value, and to apply it, more or less accurately. However, moral lines and all other aspects of morality are in a state of evolution and require reformulation when significant difficulties arise in applying them in daily life.

For example, a familiar moral line in medical practice, the distinction between ordinary and extraordinary treatment, was once meaningfully applied in making moral choices about which treatments were obligatory or optional in the care of patients with poor prognoses. This line became blurred by rapid development of technology and ambiguities presented by such patients. After many years of social debate and moral labor about the relevance of this line, some progress in reformulation occurred. Attempting to take the best interests of all into account, a President’s Commission recently recommended that when choices are made about withholding or withdrawing life-supporting treatment, the moral line should be drawn between the benefit and burden for the patient of each proposed treatment.¹

In the new field of fetal therapy, moral line drawing is especially difficult because the moral status of the fetus is a longstanding area of sociomoral conflict. The ethics of fetal therapy is in the earliest stages of moral evolution. However, approaches to some ethical problems in experimental fetal therapy, such as criteria for selection of cases, risk and benefit assessments, and the conduct of the informed consent process, have been charted by extending the research ethics practiced in other fields.²³

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This article concentrates on one controversial issue beyond experimental fetal therapy, that is, whether a pregnant woman's refusal of proven fetal therapy ought to be respected or overridden. Clearly, no moral obligation to accept unproven fetal therapy exists. But once a form of therapy is proved, as in the cases of intrauterine blood exchange for Rhesus isoimmunization, a prima facie moral obligation to accept it exists, without a stronger moral reason that overrides this obligation. How should physicians act in the event of a refusal by a competent pregnant woman of drugs or procedures, including surgery, that have been proved to help the fetus with a correctable disorder?

Future Refusals of Proven Fetal Therapy

Questions about whether a pregnant woman has moral duties toward the fetus, whether society is obligated to intervene on behalf of a fetus threatened by a woman's neglect of her health during pregnancy, and whether a legal principle of prematernal liability can be clearly formulated are being raised more frequently in the literature. Interestingly, no case of refused fetal therapy has been reported. Will refusal of proven fetal therapy be a nonproblem? As the forms of prenatal diagnosis and approaches to fetal therapy multiply, the threshold of opportunity will reach farther in all stages of pregnancy. Parents differ in their beliefs about their moral obligations to the fetus. Physician's beliefs also differ, although a trend exists toward regarding the preivable but treatable fetus as a patient. In my view, it is foolish to expect that refusals will be a nonproblem. In an open society, as the forms of fetal therapy multiply, the probability of refusals and value conflicts will increase. Not only are such cases likely to occur, but also their social and symbolic significance will surely be high. Before such cases arise, there is time to develop an optimal moral approach and prepare for the dangers and opportunities.

In an earlier discussion of this issue, I drew the line close to but not completely on the side of protecting a woman's bodily integrity when it is in conflict with avoiding probable harm to the fetus. To clarify and complete my argument, I hold that except in cases of incompetence, a moral line ought to be drawn that prevents any coercion or physical constraint aimed at overriding a pregnant woman's refusal of fetal therapy at any stage of pregnancy. This line would make forceful imposition of fetal therapy impermissible.

Cases do exist in which the woman's refusal of medical treatment in pregnancy was overridden by court order. The earliest case was in 1964 when the Supreme Court of New Jersey held that the unborn child of a hemorrhaging Jehovah's Witness who was eight months pregnant was entitled to protection, and ordered blood transfusions if physicians deemed them necessary. The transfusions were to save the life of the mother and to protect the fetus until delivery. More recent cases of court-ordered cesarean section over the parents' prior refusal of the procedure provide better parallels for discussion. Cesareans to benefit the near-term fetus and fetal therapy for the treatable, nonviable, or almost-viable fetus are not identical acts in all properties. Cesareans are a mode of delivery that alleviates dangers of proceeding with vaginal birth. In this respect, the fetus benefits as it would in fetal therapy. At times, cesareans are vital to protect the mother from danger; in fetal therapy, however, the treatment is aimed at benefiting the fetus. Therapies that benefit both mother and fetus, such as approaches to intrauterine growth retardation, are clearly permissible. Cesarean section and fetal therapy are similar enough in their benefits to the fetus to explore whether it is
ethically sound to generalize from the existing cesarean cases to what should be done in the event of refused fetal therapy. Commentators like Robertson have suggested that if these court-ordered actions are correct, then "the state may have a far-reaching power to intrude on the mother's body and freedom of action for the benefit of the unborn child." Robertson does not take the position that it is correct, but his writings have charted some pathways for future legal policies to justify intrusions on the woman, if enough sociomoral support for such policies existed. My argument is that even though this state power is discoverable, it ought to be reserved and restrained lest it do great harm to the existing persons of pregnant women and to the most central ethical principle of medical practice involving competent adults. As a matter of social policy, jurisdictions and states ought not to make laws enabling forcible imposition of fetal therapy or other interventions in pregnancy. Other methods of persuasion, education, and enlightened service to the health of pregnant women are likely to result in greater acceptance of the moral obligations of parents in pregnancy and of the benefits of fetal therapy itself.

Court-ordered Cesareans: Reliable Moral Precedents?

Irwin and Jordan collected and reported six cases of court-ordered cesareans in a recent symposium on ethical issues in the anthropology of reproduction.7

Denver—1980

A section was advised 3½ hours after the woman's membranes had ruptured because of meconium-stained amniotic fluid, electronic fetal monitoring (EFM) data suggestive of fetal distress, high station, and failure to progress. The woman was described as angry, uncooperative, and obese.8 She weighed more than 300 pounds. She refused to consent to section, indicating fear of surgery. Neither her family nor a hospital lawyer could persuade her to change her mind. After a psychiatrist judged her competent, the hospital sought a juvenile court order finding the fetus dependent and neglected and ordering a section. At the judge's request, a hearing was held in the woman's hospital room with court-appointed attorneys representing both the mother and fetus. The court ruled in favor of the hospital, and the woman relented. Surgery was performed and the baby was reported to be healthy. The initial Apgar score was 2, but the 5-minute Apgar was 8. The woman suffered from delayed healing of the incision wound.

Georgia—1981

Complete placenta previa was diagnosed 1 week before expected birth, and the woman refused a section on religious grounds. The hospital requested a court order authorizing the section as well as blood transfusions if necessary. The county Superior Court conducted an emergency hearing at the hospital at which a physician testified that a 99% probability of fetal death and a 50% probability of maternal death existed without the section. At the Supreme Court's request, Family and Children's Services sought temporary custody of the fetus through the Juvenile Court. At a joint hearing, the courts ordered treatment and assigned temporary custody to the county Family and Children's Services. The parents petitioned the Georgia Supreme Court to stay the order, but their motion was denied on the same day.9 A few days later, the mother was vaginally delivered of a healthy baby at another hospital.

Chicago—1982

A section was recommended because of three prior sections, maternal anemia, and cephalopelvic disproportion. The woman refused, with the support of her husband, for religious reasons. A juvenile court judge ruled that the fetus was suffering medical neglect. He awarded temporary protective custody to a hospital lawyer along with the power to consent to a section and to other medical or surgical procedures. It is not known if a section was actually performed, but a 6-lb baby was born, and custody reverted to the parents.
**Michigan #1—1982**

A diagnosis of placenta previa was made some weeks before the expected date of birth, and the woman refused on religious grounds to have a section. The hospital petitioned her home county court on the basis of a predicted 90% risk of fetal death. The court made the fetus a temporary ward and ordered the woman to enter the hospital for necessary treatment. The woman went into hiding with her family. Police were unable to deliver the court order in spite of repeated attempts to locate her. She delivered a healthy baby by the vaginal route 5 weeks later at another hospital.

**Michigan #2—1983**

The first child of a West African woman had been delivered vaginally after a section had been recommended and refused. In her next pregnancy, a section was advised 4 hours after admission because of secondary arrest with failure to progress, on the basis of cervical dilatation of 5 cm 2 and 4 hours after admission. Fetal heart tones were normal at the time, although earlier late decelerations had been noted. The woman and her husband refused surgery, indicating that future sections would not be available in their West African nation. It appears that an administrator contacted a local circuit judge who expressed his willingness to order a section. While this contact was in process, the woman gave birth vaginally to a healthy child with Apgar scores of 8 and 9. The couple was probably never informed of the legal maneuvers.

**California—1983**

In this case, a court-ordered cesarean was sought for the benefit of the mother, a 16-year-old Southeast Asian woman who spoke almost no English. She was admitted in labor with a breech fetus. She was accompanied by a group of family members, including her father, brother, and husband. There was little progress; the fetus did not descend, and the mother began to show signs of early pre-eclampsia. A section was advised and refused by the family, despite many efforts to explain the risks of not performing a section. The woman’s father, when told of the danger to his daughter, reportedly said, “She’s only a girl anyway.” A local judge agreed to issue an order for section, and the family was informed. At that point the patient signed the consent form. A 7-lb, 2-oz baby was delivered by section with Apgar scores of 8 and 9.

These cases show a trend toward medical and legal activism and aggressiveness in the interest of protecting the late-term fetus, with the exception of the final case. In five cases, physicians and hospital administrators began legal proceedings and were seemingly open to the possibility of coercion. Only in the Denver case was the act of coercive surgery a clear-cut possibility. In the three other cases (Georgia, Michigan #1, Michigan #2), physicians did not restrain the woman, and she had a normal vaginal delivery. One can imagine the ambivalence and conflicts as these cases unfolded. Could anything be as morally repugnant as physically restraining and tying down a pregnant woman who refused surgery? A response is that moral revulsion at coercion might be exceeded only by the revulsion at the loss of two lives in cases involving placenta previa, or in the potential death or serious injury to the fetus in the other cases. Yet despite the risk of death, I hold that except for incompetence, illustrated by the California case, pregnancy ought not to be an exception to the principle of patient consent and choice in deciding on medical care. Once inroads are made on the scope of this principle in the context of pregnancy, the potential for further societal dominance and coercion multiplies with each new technological step that could be taken to benefit the fetus. If an aura of coercion developed to surround the field of fetal therapy, its “benefits” would be ambiguous because the procedures could not be freely chosen by the parents.

The moral rights or wrongs of the decisions made in these cesarean cases is not the subject of this article. The question is, are these cases reliable sources for moral precedents to use to prepare for future
cases of refusal of fetal therapy? Four reasons can be given against this move.

First, inaccuracies and possible misdiagnosis appear to be involved in half of the cases (Georgia, Michigan #1, Michigan #2), since babies were born healthy after vaginal delivery. If precedents flow from examples flawed by faulty assumptions or mistaken evaluations, errors may be replicated. These outcomes also should remind all concerned of the possibility of misdiagnosis before fetal therapy. Forced fetal therapy on the basis of a misdiagnosis would constitute an ethical megadisaster.

Second, no adverse consequences for a newborn ensued from the five cases of refusal, and apart from the complications from the incision to the Denver woman, no harmful consequences were suffered by the women involved. Since these cases prove little in terms of consequences, they are not useful examples from which to generalize to the likely consequences of refusal of proven fetal therapy.

Third, in three cases, questions can be raised about unfairness in the decision-making process. In Denver, a hearing was held in the patient's room. Was this decision made in respect of her condition or in the hope that the physical display of the power of the state would make it easier to do what she did (i.e., relent and accept surgery)? Another location in the hospital for a hearing, if at all possible, could have been more impartially selected and arrangements made to have the woman interviewed. In Chicago, custody and power of consent were awarded to a hospital lawyer. Is a legal officer of the hospital bringing the action the fairest choice of a surrogate decision maker? In the second Michigan case, if the parents were not informed of the legal actions prior to contacts between the hospital and a judge, they were wronged.

Fourth, and most substantially, the principle of consent by competent adults to medical treatment was violated in five cases. The following section will discuss this objection.

Pregnancy: an Exception to the Consent Principle?

The President's Commission asserted that the informed consent doctrine in health care decisions is essentially an ethical imperative, although the doctrine has substantive foundations in law. Further, the Commission found that "informed consent is rooted in the fundamental recognition—reflected in the legal presumption of competency—that adults are entitled to accept or reject health care interventions on the basis of their own personal values and in furtherance of their own personal goals." The members observed, however, that patient choice was not absolute, and they marked two exceptions to the force of the principle of consent: a) when the patient's choice violates the bounds of acceptable practice or a professional's own deeply held moral beliefs, and b) when a limited resource is involved to which the patient has no binding claim. Does the first exception fit cases of refused fetal therapy? The "bounds of acceptable practice" have not yet been formulated for fetal therapy; otherwise, there would be no need to worry about moral line drawing. If a professional held moral beliefs that the fetus as a patient was entitled to primary consideration and acquiescing to the woman's refusal would violate these beliefs, he or she could clearly state these reasons before withdrawing from the case. The second exception is not relevant to refusal of fetal therapy.

However, the issue is whether coercion or forced fetal treatment would be permissible. The Commission discussed forced and coerced treatment in the context of compulsory vaccination, enforcement of criminal law (removing bullets needed as evidence), sedating uncontrollable inmates of mental hospitals, and performing some routine care in nursing homes. The Com-
mission did not take up cases in which the patient's refusal of treatment may lead to harm for others, for example, refusal of therapy for infectious or venereal disease. And the potential for coerced treatment in the context of future fetal therapy did not reach the Commission's agenda, surely because the Commission was not asked to consider it. The Commission's successor body should certainly address the question. Only two reasons could be given why pregnancy ought to be considered as an exception to the consent rule in cases of refused fetal therapy. The first, least likely to persuade, is that pregnancy is a condition functionally equivalent to a state of incapacity or incompetence. In a society in which pregnant women work and function normally until the last stage of pregnancy, this argument would not work. Another facet of the same argument would be that a choice against proven fetal therapy is equivalent to a finding of derangement or mental illness, begging the question of incompetence and opening the way for forced treatment. None of the cesarean refusal cases on record indicate that this argument has substance. If, as I believe, the five cesarean cases are a good guide to why women might refuse fetal therapy, religious and cultural differences will be the main reasons. In a nation that thrives on cultural diversity in so many respects, it is naive to expect that these differences magically disappear in medical settings. Whereas it would be unethical for indicated therapy to be denied to a living child on the basis of parental religious or cultural objection, the same cannot be categorically said of the fetus, since separation has not occurred and the only route to therapy is through the woman's body.

In my view, only one substantial argument can be made for why pregnancy is an exception to the sway of the consent doctrine, namely, that the fetus is a human being entitled to full and equal protection by society's moral and legal institutions. Can this claim be made convincingly? Our discussion began with the observation that the moral status of the fetus is a matter of sociomoral conflict. This society permits elective abortion until the end of the second trimester, and several states do not prohibit abortions in the third trimester of pregnancy. Without reviewing the several sides of the abortion issue, the controverted question of the moral status of the fetus seriously weakens any approach to overriding a woman's refusal of fetal therapy, especially any approach that envisions coercion. In a society that cherishes so highly the values that underlie the doctrine of informed consent (i.e., self-determination and respect for persons), any proposal for coercion of a competent adult for medical reasons needs justification on clear moral grounds shared in a consensus by many with a high degree of certainty. These grounds are not likely to be constructable in view of the multiplicity of weighty claims made for and against the proposal to treat fetal interests equally with those of living persons. The main reason for doubt about claims of equal protection of fetal interests is the impossibility of separating the interests of the woman from the interests of the fetus. The pregnant woman is clearly entitled to equal protection by moral and legal institutions, unless pregnancy were to be redefined as a temporary state of suspension of such protection. The obligations of society to protect the fetus are less clear, although duties may become clearer as conflict leads to new approaches.

Another instructive exercise is to attempt to draw a moral line to be used in defense of claims that the fetus is a patient entitled to medical care. One has to draw the line, as Robertson intimates, between a period when a woman was deemed to have forgone her right to abortion and any harm that might be inflicted on a viable and treatable fetus by the woman's negligent choices in consideration of proven fe-
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tal therapy. The blurriness of this line presents significant difficulties. When does a woman forgo a right to abortion? There is overlap between a period when the right to abortion is clearly incontestable and a period when fetal therapy is possible. Also, the line between viability and nonviability is notoriously gray because of technological advances in artificial life supports for premature infants. The clearest moral line for protection of fetal interests is before implantation in the uterus or in a future artificial placenta. This line can be used to prohibit any abortions except to save the life of the mother or any other exceptions that gain solid moral grounding. However, there is no way of enforcing such prohibitions without a degree of social surveillance and guarding of pregnancies that is clearly incompatible with the values of freedom and fairness so cherished in contemporary society that attach to parental choices.20

Conclusion

So, in moral line drawing for fetal therapy, one must choose which set of interests has ethical and legal priority—the woman’s or those of the fetus. The view described previously rules out any violation of the person or bodily integrity of a pregnant woman, who is a living human being with a social history, even for the good that one might do for a fetus. Too much harm would be done by forced therapy to the principle of consent. Pregnancy cannot be established as a morally valid exception to the consent rule. Additionally, the consequences of coerced or forced fetal therapy on parents would be chilling. Would women or men eagerly look forward to having children in a society willing to coerce them into fetal treatment? Would the many poor and minority women whose current access to good prenatal care is flawed by inequalities and misunderstandings, well described by Poland,21 be attracted to caregivers with backing to coerce them if necessary? In my view, a firm moral line preventing any coercion or physical constraint of pregnant women clearly fits the situation of fetal therapy today, an emerging field with many unknown risks to fetus and mother. Perhaps in the future cases of refusal will arise that present such insignificant risks to the woman and such clear benefits to the fetus that the moral line will require softening. In this era of fetal therapy, however, creative approaches, short of coercion and force, will be needed that entail clear warning about the moral consequences and potential legal liability of refusal of proven fetal therapy. A future discussion will take up the specifics of an approach to valid refusals of fetal therapy.22

References