REVIEW ARTICLE

Professionalism: An Essential Role in Caring for the Fetus as a Patient

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Abstract

The ethical obligations of the obstetrician to both the fetal patient and pregnant patient originate in the ethical concept of medicine as a profession.

Obstetricians have beneficence-based and autonomy-based obligations to the pregnant patient and beneficence-based obligations to the fetal patient, which need to be carefully balanced in different clinical situations.

The important roles of directive and nondirective counseling are explained, as well as the sometimes neglected role of preventive ethics.

Keywords: Beneficence, Ethics, Preventive ethics, Professionalism, Public trust, Respect for autonomy, Viability.

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Introduction

Professionalism is an essential component of the clinical care of the fetus as a patient. The importance of professionalism for ethics in obstetrics and gynecology has recently been underscored by the International Federation of Gynecologists and Obstetricians (FIGO). In its 2017 statement, "Professionalism in Obstetric and Gynecologic Practice," FIGO appeals to the professional responsibility model of ethics in obstetrics and gynecology.[1] In this chapter, we will explain this model[2] and its implications for the clinical care of the fetus as a patient.

Professional Responsibility Model of Obstetric Ethics and its Clinical Implications

The professional responsibility model: The ethical obligations of the obstetrician to both the fetal patient and pregnant patient originate in the ethical concept of medicine as a profession. This concept was introduced into the history of medicine by Dr John Gregory (1724–1773) of Scotland and Thomas Percival (1740–1804) of England. This concept calls for physicians to make three commitments—become and remain scientifically and clinically competent; protect and promote the health-related and other interests of the patient as the physician's primary concern and motivation and keep self-interest systematically secondary; and preserve and strengthen medicine as what Percival called a "public trust," a social institution that exists primarily for the benefit of society, not its members (in contrast to the concept of medicine as a merchant guild).[2,3]

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In the professional responsibility model, obstetricians have beneficence-based (Table 1) and autonomy-based (Table 1) obligations to the pregnant patient and beneficence-based obligations to the fetal patient.[3–5] Beneficence-based obligations are a direct function of evidence-based clinical judgment about diagnostic and therapeutic measures that are reliably expected to result in a greater balance of clinical goods over clinical harms for patients. The pregnant woman's autonomy is empowered by offering or recommending medically reasonable alternatives, that is, clinical management that is technically possible and supported by beneficence-based clinical judgment (Table 1). That a form of clinical

Table 1: Three key ethical concepts

Beneficence is an ethical principle that obligates the physician to identify and offer clinical management that in deliberative (evidence-based, rigorous, transparent, and accountable) clinical judgment is reliably expected to result in net clinical benefit for pregnant, fetal, and neonatal patients.
A medically reasonable alternative is a form of clinical management that is supported by beneficence-based deliberative clinical judgment.
Respect for autonomy is an ethical principle that obligates the physician to empower the pregnant woman to make informed and voluntary decisions with her obstetrician about the management of her pregnancy by providing her with information about medically reasonable alternatives, supporting her in understanding and evaluating the medically reasonable alternatives, and ensuring that her decisions are voluntary (free of controlling internal or external influences).

management is technically possible does not, by itself, make that form of clinical management medically reasonable. As a beneficence-based concept, medical reasonableness is not based on the preferences of the pregnant woman, especially when they are poorly informed or uninformed. Medical reasonableness is an expert clinical judgment to be made by the obstetrician.

The fetus as a patient: In the professional responsibility model of obstetric ethics, the ethical concept of the fetus as a patient plays a central role. The ethical principles of beneficence and respect for autonomy provide the basis for a clear account of this ethical concept.[3,4] The obstetrician has beneficence-based and autonomy-based obligations to the pregnant patient—the physician's perspective on the pregnant woman's health-related interests provides the basis for the physician's beneficence-based obligations to her, whereas her own perspective on those interests provides the basis for the physician's autonomy-based obligations to her. Because of an insufficiently developed central nervous system, the fetus cannot meaningfully be said to possess values and beliefs. Thus, there is no basis for saying that a fetus has a perspective on its interests. There can therefore be no autonomy-based obligations to any fetus. Hence, the language of fetal rights has no meaning and, therefore, no application to the fetus in obstetric clinical judgment and practice.[2–6] The obstetrician has a perspective on the fetus's health-related interests and, therefore, can have beneficence-based obligations to the fetus, but only when the fetus is a patient.[3,4]

The ethical concept of the fetus should guide clinical obstetric judgment and practice.[3,4,6] When the fetus is a patient, directive counseling, that is, recommending a medically reasonable alternative for fetal benefit, is appropriate. For example, the obstetrician should recommend cesarean delivery for well-documented, intrapartum complete placenta previa. When the fetus is not a patient, nondirective counseling, that is, offering but not recommending medically reasonable alternatives for fetal benefit, is appropriate. For example, a woman with a prior low transverse incision should be offered both planned cesarean delivery and a trial of labor after cesarean delivery in a hospital that meets accepted standards.

The concept of the fetus as a patient derives from the concept of being a patient, which was introduced into the history of medical ethics by Gregory and Percival—a human being becomes a patient when that human being is presented to a physician, and there exist one or more medically reasonable alternatives for managing that human being's clinical condition.[3,4] The authors have argued elsewhere that beneficence-based obligations to the fetus exist when the fetus is reliably expected later to achieve independent moral status as a child and person.[3,4] That is, the fetus is a patient when the fetus is presented for medical interventions, whether diagnostic or therapeutic, that reasonably can be expected to result in a greater balance of goods over harms for the child and person the fetus can later become during early childhood. The clinical applicability of this concept in obstetric practice is a function of the links that can be established between the fetus and its later achieving independent moral status.[3,4]

The viable fetal patient: One such link is viability, which must be understood in terms of both biological and technological factors. It is only by virtue of both factors that a viable fetus can exist *ex utero* and thus achieve independent moral status. When a fetus is viable, that is, when it is of sufficient maturity so that it can survive into the neonatal period and achieve independent moral status given the availability of the requisite technological and professional support, and when it is presented to the physician, the viable fetus is a patient. Viability exists as a function of biomedical and technological capacities, which are different in different parts of the world. As a consequence, there is, at the present time, no worldwide, uniform gestational age to define viability. In the United States and other high-income countries, viability should be understood to exist at approximately 24 weeks of gestational age.[3,7,8]

Beneficence-based directive counseling: When the fetus is a patient, directive counseling for fetal benefit is ethically justified. This directive counseling empowers the pregnant woman to exercise her autonomy and, therefore, should not be considered paternalism. Beneficence-based directive counseling includes recommending against termination of pregnancy, recommending against nonaggressive management, or recommending aggressive management. Aggressive obstetric management includes interventions such as fetal surveillance, administration of steroids, tocolysis, cesarean delivery, or delivery in a tertiary care center when indicated. Nonaggressive obstetric management excludes such interventions.

Beneficence-based directive counseling should always take into account the presence and severity of fetal anomalies and extreme prematurity and beneficence-based obligations to the pregnant woman related to her medical condition.[3,9]

The strength of beneficence-based directive counseling varies according to the presence and severity of anomalies. As a rule, the more severe the fetal anomaly, the less directive counseling should be for fetal benefit. In particular, when anomalies incompatible with neonatal survival, even with intervention, such as anencephaly, are diagnosed with certainty, there are no beneficence-based obligations to provide aggressive management. Such fetuses should be regarded as dying patients. Counseling should be nondirective in recommending between nonaggressive management and termination of pregnancy but directive in recommending against aggressive management for the sake of maternal benefit.[3,9] By contrast, third-trimester abortion for Down syndrome or achondroplasia is not ethically justifiable because the future child with high probability will have the capacity to grow and develop as a human being.[3,10,11]

Beneficence-based directive counseling in cases of extreme prematurity is appropriate. At 22 weeks gestation, the fetus should not be considered viable, and only nonaggressive obstetric management or termination preceded by feticide should be offered. At 23 weeks, there is controversy about the neonatal benefit of aggressive obstetric management followed by neonatal intensive care. This means that both nonaggressive and aggressive obstetric management is medically reasonable. Both should be offered and very carefully considered by the pregnant and those involved in her decision in a deliberative shared decision-making process. At 24 weeks, in the absence of severe fetal anomalies, aggressive obstetric management should be recommended in centers with an evidence base for good outcomes.[3,8]

Beneficence-based directive counseling and shared decision-making should always be guided by deliberative balancing of beneficence-based obligations to the fetal patient against beneficence-based and autonomy-based obligations to the pregnant woman. It should be emphasized, as a matter of preventive ethics, to the pregnant woman and those involved in her decision-making that she is ethically obligated to take not just any risk but only reasonable risks of medical interventions for potential fetal benefit.

Preventive ethics: The obstetrician should be alert in the decision-making process to the emerging potential for conflict between the physician's recommendation and a pregnant woman's autonomous decision not to authorize that recommendation. Such ethical conflict is best managed preventively through the informed consent process as an ongoing dialogue throughout a woman's pregnancy, augmented as necessary by negotiation and respectful persuasion.[3,12]

The previable fetal patient: The only possible link between the previable fetus and the child it can become is the pregnant woman's autonomy because technological factors alone do not result in the previable fetus becoming a child. The link, therefore, between a fetus and the child it can become, when the fetus is previable can be established only by the pregnant woman's decision to confer the status of being a patient on her previable fetus. Because autonomy-based obligations, as explained above, do not apply to the fetus, the previable fetus has no claim to the status of being a patient independently of the pregnant woman's autonomy. The pregnant woman is free to withhold, confer, or, having once conferred, withdraw the status of being a patient on or from her previable fetus according to her own values and beliefs. The previable fetus is presented to the physician as a function of the pregnant woman's autonomy.[3,4]

Counseling the pregnant woman regarding the management of her pregnancy when the fetus is previable should be nondirective in terms of continuing or terminating the pregnancy if she refuses to confer the status of being a patient on her fetus.[3,5] The obstetrician should make a direct or indirect referral for termination of pregnancy.[13] If she does confer such status in a settled way, at that point, beneficence-based obligations to her fetus come into existence, and directive counseling for fetal benefit becomes appropriate for these previable fetuses. This will apply to most pregnancies. Just as for viable fetuses, such counseling must take account of the presence and severity of fetal anomalies, extreme prematurity, and obligations owed to the pregnant woman.

For pregnancies in which the woman is uncertain about whether to confer such status, the authors propose that the fetus be provisionally regarded as a patient. This justifies directive counseling against behavior that can harm a fetus in significant and irreversible ways, for example, substance abuse, especially alcohol, until the woman settles on whether to confer the status of being a patient on the fetus.

Conclusion

The ethical concept of the fetus as a patient and the professional responsibility model of obstetric ethics in which this concept is expressed should guide clinical judgment and practice in obstetrics. The commitment to professionalism is therefore essential for the clinical care of pregnant, fetal, and neonatal patients. The professional responsibility model distinguishes between the viable and previable fetal patient and identifies the roles of beneficence-based directive counseling, nondirective counseling, and preventive ethics. Counseling pregnant women about the clinical management of their pregnancies should always identify and balance beneficence-based obligations to the fetal patient and beneficence-based and autonomy-based obligations to the pregnant patient.

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