Spring 2009

Understanding a Woman's Moral Obligation to her Fetus: Maternal-Fetal Conflict as a Covenant Relationship

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UNDERSTANDING A WOMAN'S MORAL OBLIGATION TO HER FETUS: MATERNAL-FETAL CONFLICT AS A COVENANT RELATIONSHIP

A Dissertation

Submitted to the Center for Healthcare Ethics

McAnulty College and Graduate School of Liberal Arts

Duquesne University

In partial fulfillment of the requirements for

the degree of Doctor of Philosophy

By

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May 2009

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ABSTRACT

UNDERSTANDING A WOMAN'S MORAL OBLIGATION TO HER FETUS: MATERNAL-FETAL CONFLICT AS A COVENANT RELATIONSHIP

By

Marianne Louise Burda, M.D.

May 2009

Dissertation supervised by Professor Gerard Magill

Maternal-fetal conflict refers to a perceived incompatibility between the interests of a pregnant woman and her fetus. Maternal-fetal conflict can occur when a pregnant woman declines a medical treatment or procedure that her physician believes is necessary to benefit her fetus. In some situations, the pregnant woman's health is also at risk. The question explored in this dissertation is: what is the pregnant woman's moral obligation to her fetus when a cesarean section is recommended to save the life of or to prevent serious harm to her term viable fetus? The pregnant woman's life is not endangered.

Inconsistencies exist between normative theories and approaches to resolving maternal-fetal conflict. Legally, the pregnant woman's liberty rights allow her to accept or refuse treatment for her and/or her fetus. But states have an interest in protecting the potential life of the fetus even though it is not a person with rights under the United States Constitution. Philosophically, inconsistencies exist between the principles of

justice and respecting the pregnant woman's autonomy and the principles of beneficence and nonmaleficence, along with the pregnant woman's duties to her fetus as her future child. Professionally, medical organizations support respecting the pregnant woman's autonomy and treating the pregnant woman and her fetus as one patient. However, some physicians favor beneficence toward the fetus and view the pregnant woman and fetus as two separate patients. Obstetricians are increasingly performing cesarean section as an elective alternative to vaginal delivery. From the religious perspective, Catholicism, Judaism, and Islam differ in their moral teachings on the status of the fetus as a person.

The pregnant woman can adopt a hermeneutical stance that gives depth of meaning to her autonomous decision based on normative theories and approaches. The pregnant woman can interpret her developing relationship with her fetus throughout her pregnancy as a covenant relationship of gift, love, faithfulness, and fidelity. The covenant relationship is expressed in the Judeo-Christian biblical covenant relationships between God and humans. The covenant relationship can also be understood on a secular level.

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DEDICATION

To Mom, Dad, Philip, and Uncle John,

Whose love and support through the years made everything possible.

ACKNOWLEDGEMENT

Much thanks to my dissertation director Dr. Gerard Magill for guiding me on this interesting and educational journey and the exploration of previously unknown paths. Much thanks also to my committee members Dr. Aaron Mackler and Dr. Rhonda Hartman for their guidance and insightful comments. I am grateful to the committee for sharing their knowledge and wisdom with me throughout this journey, along with their support. Thanks also to the staff of the Gumberg Library of Duquesne University for their constant assistance throughout this endeavor. And thanks to Kathleen, Martina, and the staff at the National Center for Bioethics Literature at the Kennedy Institute of Ethics for all of their help with my research.

To my family and friends who have accompanied me on this long journey, a huge thank you. I am especially grateful to Mom and Philip who are always there for me. I could not have done this without you two and your support and encouragement. Thanks also to Christie, Carol, Bill, and Uncle Bill. To Urban and Kathy, Catherine, Cathy, and Stephanie, you are true lifelong friends I can count on no matter where our paths take us. Thanks also to Dennis, Kathy, and Kathy who shared this academic journey and made it enjoyable. May your journeys also come to a successful end. Thanks to the Marquette gang – you always provide a break and a laugh just when I needed it.

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TABLE OF CONTENTS

Page

Abstract iv

Dedication vi

Acknowledgement vii

Chapter 1 Introduction to Maternal-Fetal Conflict 1

1.1 Maternal-Fetal Conflict 1

1.1a Definition 1

1.1b Situations of Maternal-Fetal Conflict 2

1.1c Reasons for Maternal-Fetal Conflict 3

1.1d Prevalence of Maternal-Fetal conflict 4

1.2 Dissertation Question 4

1.3 Normative Theories and Approaches to Maternal-Fetal Conflict 5

1.3a Legal 5

1.3b Philosophical 7

1.3c Professional Medical Organizations 8

1.3d Religious 9

1.3e Summary 10

1.4 Maternal-Fetal Relationship as Legal Contract 11

1.4a Definition of Legal Contract 11

1.4b Promise Keeping and Moral Obligations 12

1.4c Legal Contract Model Insufficiencies 12

1.5 Hermeneutic Stance 14

1.5a Covenant Relationship 14

1.5b Covenant, Personhood, and Consent 15

1.5c Ethics of Care 16

1.5d Covenant Relationship and Community 17

1.5e Physician-Patient Covenant Relationship 17

1.5f Summary 17

1.6 Chapter Summary 18

1.6a Chapter Two 18

1.6b Chapter Three 18

1.6c Chapter Four 19

1.6d Chapter Five 19

1.6e Chapter Six 19

1.6f Chapter Seven 20

Chapter 2 The Fetus and The Law 24

2.1 Introduction 24

2.2 Abortion Laws 25

2.2a Roe versus Wade 25

2.2b Planned Parenthood of S.E. Pa. v. Casey 28

2.2c Gonzales v. Carhart 31

2.2d Summary 32

2.3 Forced or Court Ordered Cesarean Section Cases 33

2.3a Jefferson v. Griffin Spalding County Hospital Authority 33

2.3b In Re A.C. 36

2.3c Doe v. Doe 39

2.3d Pemberton v. Tallahassee Memorial Regional Medical Center..... 42

2.3e Summary 45

2.4 Legal Principles 45

2.4a Liberty, Privacy, Due Process, and Bodily Integrity 46

2.4b State Interests 52

2.4c Summary……56

2.5 Advance Directives and Pregnancy 56

2.5a Definition – Advance Directives..... 57

2.5b Pregnancy Clauses 58

2.5c Summary 63

2.6 Criminal Law and the Fetus 64

2.6a Federal Law..... 64

2.6b State Law 65

2.6c Summary 66

2.7 Federal Research Laws 66

2.8 Conclusion 68

Chapter 3 Philosophical Views of Maternal-Fetal Conflict 78

3.1 Introduction..... 78

3.2 Principlism 79

3.3 Respect for Autonomy 81

3.3a Definition 81

3.3b Respect for Autonomy and Pregnancy 83

3.4 Balances to Autonomy 85
3.4a Justice 86
3.4b Nonmaleficence 87
3.4c Beneficence 88
3.4d Obligations of Beneficence 89
3.4e Conflicts of Respect for Autonomy, Beneficence, and Nonmaleficence 91
3.5 Duty to the Fetus 93
3.5a Consequentialism and Deontology 93
3.5b Beneficence and Nonmaleficence in Duty Theory 95
3.5c Moral Role Obligations to the Fetus 96
3.5d. Summary 99
3.6 Kantian Ethics and the Fetus 100
3.6a Definition of Person 101
3.6b Status of Fetus 103
3.6c Parental Obligations to Children 106
3.6d Summary 109
3.7 Kantian Duties Toward Fetuses 109
3.7a Indirect Duties 109
3.7b Duties Based on the Categorical Imperative 110
3.7c Duty of Beneficence 113
3.7d Duties in the Doctrines of Virtue and Rights 116
3.7e Summary 120
3.8 Conclusion 120

Chapter 4 Professional Views of Maternal-Fetal Conflict 127

4.1 Introduction 127

4.2 Professional Medical Organization Views 128

4.2a Guidelines and Opinions 128

4.2b American Medical Association 130

4.2c American College of Obstetricians and Gynecologists 133

4.2d RCPSC 137

4.2e FIGO 139

4.2f RCOG 141

4.2g Summary 144

4.3 Research on Physician's Perceptions and Practices 145

4.3a Before Guidelines 146

4.3b After ACOG 147

4.3c After Guidelines 150

4.3d European Stance 152

4.3e Studies and Organizational Views 153

4.4 Fetus as Patient 156

4.4a One-Patient Model 156

4.4b Changes in the Fetus' Status 157

4.4c Two-Patient Model 159

4.4d Summary 162

4.5 Cesarean Delivery on Maternal Request 163

4.5a Definition and Incidence 163

4.5b Scientific and Ethical Issues 164

4.5c Physician and Organizational Views 165

4.6 Conclusion 166

Chapter 5 Religious Moral Treatment of Maternal-Fetal Conflict..... 174

5.1 Introduction..... 174

5.2 Sanctity of Life and Status of the Fetus 175

5.2a Catholic 175

5.2b Jewish..... 177

5.2c Islamic 180

5.2d Summary 183

5.3 Autonomy, Informed Consent, and Stewardship..... 184

5.3a Catholic 184

5.3b Jewish..... 189

5.3c Islamic 193

5.3d Summary 195

5.4 Abortion 196

5.4a Catholic 196

5.4b Jewish..... 200

5.4c Islamic 204

5.4d Summary 206

5.5 Other Religious Teachings..... 207

5.5a Love of Neighbor 207

5.5b Morally Ordinary and Extraordinary Treatment 210

5.6 Conclusion 211

Chapter 6 Maternal-Fetal Relationship as Covenant 220

6.1 Introduction 220

6.2 Contract Model 223

6.2a Legal – Definition 224

6.2b Promise, Obligation, Duty 226

6.2c Physician – Patient Model 227

6.2d Maternal-Fetal Model 229

6.2e Summary 236

6.3 Hermeneutical Stance 237

6.3a Definition 238

6.3b Maternal-Fetal Relationship 240

6.4 Biblical Covenant Relationships 242

6.4a Covenant of Promise 243

6.4b Covenant Treaty 245

6.4c New Testament Covenant Relationship 247

6.4d Summary 248

6.5 Maternal-Fetal Covenant Relationship 249

6.5a Similarities Between Biblical and Maternal-Fetal Covenant Relationships 249

6.5b Gift and Charity 250

6.5c Faithfulness and Fidelity 253

6.5d Secular Covenant Relationship 256

6.5e Virtue and Character 257
6.5f Summary 258
6.6 Other Interpretations 259
6.6a Covenant, Personhood, and Consent 260
6.6b Ethic of Care and Covenant 261
6.6c Covenant Relationship and Community 272
6.6d Physician-Patient Covenant Relationship 274
6.6e Summary 275
6.7 Applications of Covenant Relationship 275
6.7a Specific Clinical Examples of the Dissertation Case 275
6.7b Use in Maternal-Fetal Conflict 278
6.8 Conclusion 279
Chapter 7 Conclusion 289
7.1 Introduction 289
7.2 Normative Theories and Approaches 290
7.2a Legal 290
7.2b Philosophical 292
7.2c Professional Medical Organizations 293
7.2d Religious 294
7.2e Summary 295
7.3 Hermeneutical Stance 295
7.4 Limitations 296
7.4a Normative Limitations 296

7.4b Hermeneutical Limitations..... 298
7.4c Summary..... 299
7.5 Implications..... 300
7.5a Policy..... 300
7.5b Research..... 302
7.5c Education..... 304
7.5d Summary..... 305
7.6 Conclusion..... 306
BIBLIOGRAPHY..... 309

Chapter 1

Introduction to Maternal-Fetal Conflict

1.1 Maternal-Fetal Conflict

The definition of maternal-fetal conflict is presented in chapter one, along with clinical examples and reasons why conflict occurs.

1.1a Definition

Maternal-fetal conflict is defined by Adams, et al. as "a perceived incompatibility between the interests of pregnant patients and those of the fetus."[1] Maternal-fetal conflict can occur when a pregnant woman declines a medical treatment, procedure, or surgery that her physician believes is necessary to benefit the health of her fetus.[2] In some situations the pregnant woman's health is also at risk. Maternal-fetal conflict is also referred to as maternal-doctor conflict.[3] The term maternal-doctor conflict reframes the situation as being between the pregnant woman and her physician.[4] The conflict is now defined as the physician and the pregnant woman disagreeing about recommended medical care or treatment.[5] In both maternal-fetal and maternal-doctor conflict, the

interests at stake for the pregnant woman are respect for her autonomy and liberty rights, which allow her to make decisions concerning her and her fetus' medical care and treatment, versus her duty to the fetus as her future child and the state's interest in preserving potential life. In maternal-doctor conflict, the doctor's interests are based in acting beneficently toward the fetus and pregnant woman and not causing harm, along with the doctor's duties towards his or her patients.

1.1b Situations of Maternal-Fetal Conflict

Regardless of what terminology one uses to describe this type of conflict, it usually occurs in situations in which the health, or even the life, of the fetus woman is threatened if the pregnant woman does not undergo the recommended medical treatment, procedure, or surgery. The pregnant woman's life or health may also be at risk. The physician must make recommendations for medical care and treatment based on his or her best medical assessment of the situation. The physician is never able to predict with one hundred percent certainty what the outcome of the situation will be with or without the recommended medical care and treatment. There is always a chance that the physician's assessment may be wrong.

Recommended medical treatments or procedures can range from those that are non-invasive, e.g., diet modification, limitations of the pregnant woman's activities, ultrasound, fetal non-stress testing or monitoring, to those that require some discomfort, e.g., insulin or progesterone injections, to invasive procedures e.g., insertion of central lines or feeding tubes, and surgery, e.g., appendectomy, ovarian cystectomy. At times, a medical treatment, procedure, or surgery is recommended solely for the benefit of the fetus. Examples include ultrasounds, fetal testing and monitoring, induction of labor,

cesarean section, or in-utero fetal surgery. Cesarean section, in-utero fetal surgery, and other surgical procedures are invasive and entail at least minimal risk to the pregnant woman, such as bleeding, infection, etc.

1.1c Reasons for Maternal-Fetal Conflict

The pregnant woman may disagree with her physician's recommendations for various reasons. These reasons can include, as Joel Jay Finer writes:

> religious beliefs, fear of stigmatization, fear of surgery, fear of dying, disbelief of the medical diagnosis, and their desire not to have the baby. Women may also refuse because of the undesirability of an abdominal scar, because of the pathological denial of pregnancy (especially teenagers), or because of depression or other mental disability.[6]

A less common reason is the pregnant woman not wanting to be inconvenienced by the recommended medical care or treatment. Often she may agree that her physician's assessment of the medical situation is correct, but she believes that she and her fetus will be fine without the recommended medical care or treatment.[7] Conflicting or inaccurate information obtained from sources other than her physician, such as the internet, friends, or family, can also contribute to the disagreement.[8]

Unfortunately, in some cases, one never truly knows the pregnant woman's reasons for declining recommended medical care or treatment and if a fully informed and competent decision is being made. Fear, lack of understanding of the medical situation and/or risks and benefits of the recommended medical care or treatment, or pressure or coercion from family members or others can all influence a pregnant woman's decision. An autonomous decision may not be made due to one or more of these conditions being present.[9] As with any patient, the physician must be sure that the pregnant woman

possesses decision-making capacity and that she is presented with all of the information needed to make a fully informed decision.[10]

1.1d Prevalence of Maternal-Fetal conflict

No statistics exist as to the prevalence of maternal-fetal conflict. Most instances of maternal-fetal conflict occur within the setting of the physician-patient relationship and/or when the pregnant woman is a patient in the hospital. Other individuals usually become aware of these conflicts when they escalate to the point where a physician or administrator requests judicial intervention in order to compel the pregnant woman to undergo treatment. These legal cases make up only a portion of all of the cases of maternal-fetal conflict that occur. Forced treatment or the threat of forced treatment can result in the pregnant woman avoiding physicians and other health care providers and facilities.[11] When this happens, the pregnant woman does not receive appropriate medical care during pregnancy, labor, and delivery.[12]

1.2 Dissertation Question

The question examined in this dissertation is: what is the pregnant woman's moral obligation to her fetus when faced with a situation of maternal-fetal conflict? The situation considered is when a pregnant woman's obstetrician recommends a cesarean section to save the life of or prevent serious harm to her term viable fetus. The pregnant woman's life is not endangered. There is no additional risk of morbidity and mortality to the pregnant woman above that of a routine cesarean section. The dissertation assumes the doctor is correct in concluding there is a very high probability of the fetus not dying or being seriously harmed if delivered by cesarean section.

How one answers this question varies greatly depending on one's beliefs and views. Legal, philosophical, professional, and religious normative theories and approaches to maternal-fetal conflict are not consistent. Differences exist within and between these four areas as to the pregnant woman's moral obligations. Beliefs and values differ, leading to the lack of common ground to resolve maternal-fetal conflict. However, the pregnant woman must make her decision based on these inconsistencies. The hermeneutic stance of covenant relationship will be proposed to give ethical meaning to the pregnant woman's autonomous decision.

The dissertation question is limited to this particular situation of maternal-fetal conflict. The ideas presented here may possibly apply to other situations of maternal-fetal conflict, including when in-utero fetal surgery or other medical therapies or procedures are recommended solely for the fetus' benefit. The dissertation does not consider when a cesarean section is needed to save the pregnant woman's life or both the pregnant woman's and fetus's life.

1.3 Normative Theories and Approaches to Maternal-Fetal Conflict

Legal, philosophical, professional medical organizations, and religious normative theories and approaches used to resolve maternal-fetal conflict are examined in this dissertation. Inconsistencies within and between theories are analyzed.

1.3a Legal

One legal position on maternal-fetal conflict is based on the pregnant woman's liberty rights and the principle of self-determination.[13] United States federal and state courts ruled that a competent, fully informed pregnant woman can refuse a cesarean

section even if it results in harm or death to the fetus and/or the pregnant woman. Earlier court rulings favored protecting the fetus.[14] Adams, et al. explains that "a patient's right to refuse treatment is protected by the traditional common law rights of bodily integrity."[15] The right of a pregnant woman to refuse a cesarean section is based on the liberty right found in the Due Process Clause of the Fourteenth Amendment. The Due Process Clause, according to Black's Law Dictionary, is "the constitutional provision that prohibits government from unfairly or arbitrarily depriving a person of life, liberty, or property."[16] Liberty in this context is defined, according to Adams, et al., as "a constitutional right to be free of unwanted physical invasions."[17]

L. Syd M. Johnson points out that "in Roe v. Wade (1973), the Supreme Court held that fetuses are not persons as defined by the 14th Amendment of the Constitution."[18] Therefore, the fetus does not have the same legal rights as the pregnant woman.[19] Despite this, states do have an interest in preserving life, including potential life. In general, the state interest increases as the degree of invasiveness of the procedure or treatment decreases.[20] A number of states, in order to protect the fetus, do not allow a pregnant woman's living will or advanced directive to be followed if doing so results in harm or death to the fetus.[21] The pregnant woman's autonomous decisions concerning end-of-life care, made when she was competent, are not honored until the fetus is born. Other states allow for some exceptions under which the living will can be followed.[22] Pennsylvania's Advance Directive Statute Section 5414 allows life-sustaining treatments, nutrition and hydration to be withdrawn or withheld if it:

> (1) will not maintain the pregnant woman in such a way as to permit the continuing development and live birth of the unborn child;
> (2) will be physically harmful to the pregnant woman; or

(3) would cause pain to the pregnant woman which cannot be alleviated with medicine.[23]

State and federal fetal homicide laws give status to the fetus by permitting charges to be filed if a fetus is murdered. Federal regulations governing research involving pregnant women may require the father's consent when the research only benefits the fetus. The consent of the pregnant woman is not sufficient per the Code of Federal Regulations, Title 45, Part 46.[24]

1.3b Philosophical

The bioethical principle of respect for autonomy recognizes a person's right to have his or her own beliefs, to make choices, and to act based on one's beliefs and values.[25] Respect for autonomy allows competent adults to make their own decisions regarding medical care and treatment. Medical professionals are obligated to respect the autonomous individual's judgment, even if they disagree or if the refusal of treatment results in the patient's death.[26] Respect for autonomy includes pregnant women who make autonomous decisions for themselves and their fetuses.[27] A pregnant woman, based on respect for autonomy, can refuse a cesarean section that saves the life of or prevents harm to her and/or her viable fetus.[28] The principle of justice requires pregnant and non-pregnant women to have the same rights.[29]

Contrasting with respect for autonomy and justice are the principles of nonmaleficence and beneficence. Nonmaleficence requires the pregnant woman not to harm the fetus. Beneficence requires the pregnant woman to act for the fetus' benefit.[30] Some philosophers believe the pregnant woman has duties to her fetus as her future child based on her role and relationship as a future parent.[31]

1.3c Professional Medical Organizations

Major professional medical organizations, such as the American College of Obstetricians and Gynecologists and the American Medical Association, support respecting the autonomy of the pregnant woman as the primary guiding principle in situations of maternal-fetal conflict.[32] But once again, differences of opinion exist. Studies show individual physicians do not always agree with the professional organizations' guidelines and opinions. According to Adams, et al., physicians "gave higher priority to respect for fetal life, medical tradition, and beneficence (defined in medical terms) than to maternal autonomy, bodily integrity, or privacy."[33] They also write:

> Many physicians are more troubled by pregnant women's refusal of treatment when the fetus is closer to term than they are earlier in gestation. They are also more troubled when the treatment refused is 'standard of care', when it entails little risk to the woman, and when it is likely to prevent severe damage to the potential child.[34]

Many obstetricians believe they have two patients, the pregnant woman and the fetus, to which they have separate obligations.[35] The specialty of maternal-fetal medicine, also referred to as perinatology or high-risk obstetrics, continues to develop more treatments and procedures solely to benefit the fetus in-utero. Fetal therapy centers staffed by perinatologists, pediatric surgeons, cardiologists and other specialists, neonatologists, and geneticists are becoming more prevalent.[36] The centers focus on in-utero surgery and procedures to address fetal health problems.[37] However, professional medical organizations support treating the pregnant woman and her fetus as one patient, a maternal-fetal dyad.

Cesarean section as an elective procedure performed at the pregnant woman's request without a medical indication is on the rise.[38] In the United States and many other countries, cesarean section is increasingly accepted as an alternative to vaginal delivery. Cesarean sections are no longer performed only when medically indicated in situations when vaginal delivery is not appropriate.[39] Professional medical organizations disagree, recommending cesarean section only when medically indicated.

1.3d Religious

Religious moral theories concerning maternal-fetal conflict also vary and are based primarily on the status of the fetus. The Catholic Church believes that the fetus from the moment of conception is to be treated as a person with full rights. The Sacred Congregation for the Doctrine of the Faith's teaching "Instruction on Respect for Human Life" (1978) states that: "the human being is to be respected and treated as a person from the moment of conception and therefore from that same moment its rights as a person must be recognized, among which in the first place is the inviolable right of every innocent human being to life."[40] The lives of the pregnant woman and fetus are equal and have the same dignity and worth, giving the fetus the same right to life as the pregnant woman. In addition, the Catholic teachings of love of neighbor, the fetus not being viewed as an unjust aggressor, morally ordinary and extraordinary medical treatment, and stewardship also determine the moral obligations of the pregnant woman.

The moral obligations of the pregnant woman may vary between the different branches of Judaism. Orthodox Judaism looks to halakhah for guidance.[41] Conservative Judaism also looks to halakhah but gives some consideration to autonomy.[42] Reform Judaism considers the autonomy of the pregnant woman primary, with some

consideration given to halakhah.[43] The result is the three branches differ on the weight given to the principles of autonomy, ownership of one's body, and fetal rights and status. All branches believe a fetus is not considered a person in Judaism until it is born. Therefore, the fetus does not have the same rights as the pregnant woman.[44] All branches accept abortion when the pregnant woman's life is endangered.[45] However, life is sacred in Judaism. As Ben Zion Bokser and Kassel Abelson write "the fetus is a life in the process of development, and the decision to abort it should never be taken lightly."[46]

In Islam, 120 days of gestation is when the fetus is considered a person, ensoulment takes place, and the fetus has a right to life.[47] Abortion is only permitted after 120 days if the pregnant woman's life is endangered.[48] The permissibility of abortion prior to 120 days in Islam is debatable. Some schools permit abortion only if the pregnant woman's life is at risk, while other schools are not as strict.[49] Life is sacred in Islam.[50] Islamic law and moral teachings determine the woman's moral obligations in maternal-fetal conflict.

1.3e Summary

There are inconsistencies in the law as to the liberty rights of the pregnant woman versus state interests in protecting the potential life of the fetus and state laws that invalidate a pregnant woman's living will or advanced directive.[51] Inconsistencies are also found in philosophical principles of respect for autonomy and justice and the principles of beneficence and nonmaleficence, along with the pregnant woman's duties toward her fetus. There are inconsistencies between the recommendations of major professional medical organizations and some obstetricians on their views of the fetus as a patient.[52] They also differ as to whether respect for the pregnant woman's autonomy or

beneficence is the guiding principle in maternal-fetal conflict. Views on indications for cesarean section also differ. Teachings on the status of the fetus, abortion, and the pregnant woman's moral obligations toward her fetus vary between religions and may also differ from the legal and secular views.

Inconsistencies exist in the normative theories and approaches used to resolve maternal-fetal conflict. Common ground on which to resolve maternal-fetal conflict does not exist. Therefore, the involved parties may have different beliefs, resulting in an escalation of the conflict.

1.4 Maternal-Fetal Relationship as Legal Contract

A possible alternative common normative approach or theory to consider for resolving maternal-fetal conflict is contract.

1.4a Definition of Legal Contract

Some believe that a pregnant woman who does not exercise her legal option to abort her pregnancy when permissible automatically enters a contractual agreement with her fetus to continue the pregnancy.[53] The unwritten or implied contract supposedly requires the pregnant woman to do what is necessary to result in the live birth of the fetus. Whether this type of contract between the pregnant woman and her fetus exists and whether it provides a principled model warrants close scrutiny.

Legally, contracts are defined by West's Encyclopedia of American Law as "agreements between two or more persons that create an obligation to do, or to refrain from doing, a particular thing."[54] Contracts are a result of self-interest. Per William F. May, they provide "for the legal enforcement of its terms - on both parties - and thus

offers both parties some protection and recourse under the law for making the other accountable for the agreement."[55] The typical contract parties enter into is a bilateral contract. Bilateral contracts must include promises on the part of both parties and a mutuality of obligations.[56]

1.4b Promise Keeping and Moral Obligations

The moral principle underlying contracts is the keeping of promises. Keeping of promises allows a contract to endure and creates an obligation. Entering into a contract obligates one or more parties to provide certain goods or services in exchange for some other service or payment.[57] Obligation is defined by West's Encyclopedia as:

> a generic term for any type of legal duty or liability…and is anything that an individual is required to do because of a promise, vow, oath, contract, or law. It refers to a legal or moral duty that an individual can be forced to perform or penalized for neglecting to perform.[58]

The normative contract model is used in medicine to describe the physician-patient relationship. The physician-patient contract is rooted in mutual respect and each party's rights, duties, and autonomy.[59] The physician-patient contract limits the physician's obligations and involves trust.[60] The physician-patient contract spells out the minimal obligations of the physician.[61]

One can similarly view the maternal-fetal relationship as a contractual relationship. The maternal-fetal contract spells out the minimal obligations of the pregnant woman to her fetus. The contract can be looked to for resolving disagreements.

1.4c Legal Contract Model Insufficiencies

In reality no such contract exists between the pregnant woman and fetus. The fetus cannot consent to entering into any agreement with the pregnant woman. The fetus

is incapable of expressing thoughts or communicating in any manner. The fetus cannot agree on terms of services and goods that make up the contract. The fetus cannot make or keep promises that are part of contracts.

The contract really states that the pregnant woman is obligated to see the fetus to a live birth only if she chooses to do so. She is under no legal obligation to continue her pregnancy until birth, even if she chose not to have an abortion when legally permissible. She is under no legal obligation to undergo any medical or surgical procedure to benefit the fetus' health. The courts allow her an out to any so-called contract she has made with her fetus.

The pregnant woman cannot be held for breach of contract with the fetus. Breach of contract is defined by West's Encyclopedia as "an unjustifiable failure to perform all or some part of a contractual duty."[62] She cannot be held to the typical remedy of specific performance, which West's Encyclopedia defines as "an equitable remedy by which a person is required to execute, as nearly as practical, a promised performance because monetary damages are inadequate to compensate for the breach."[63] Using this standard requires overriding the pregnant woman's autonomy and liberty rights.

If the pregnant woman believes she is morally obligated to keep her promise to the fetus she will act for the fetus' benefit. But a moral obligation does not translate into a legally obligation for the courts.[64] The moral duty may result from the pregnant woman acting out of beneficence and nonmaleficence towards her fetus. She makes an autonomous decision to do good for her fetus or to not cause harm to the fetus. The pregnant woman may also believe she is morally obligated based on deontological moral

theories that require one never to break a promise. Or she may believe her moral obligation is based on her duties to her fetus as her future child.

The idea of contract is insufficient as a normative theory or approach to resolving maternal-fetal conflict for several reasons. First, the pregnant woman's legal right to refuse medical care or treatment carries no obligation to undergo a treatment or procedure for the benefit of her fetus. Second, the fetus is unable to actually enter into any contract or agreement with the pregnant woman. Third, the pregnant woman cannot be held to specific performance for breaching the contract. Conflicts can still occur between pregnant women, their physicians, and others involved in the pregnant woman's care due to differences in the legal and moral requirements of contract. Contract does not provide common ground for resolving maternal-fetal conflict.

1.5 Hermeneutic Stance

Based on the above inconsistencies, one can conclude there is no agreed upon normative approach or theory to provide common ground for all parties in resolving a situation of maternal-fetal conflict. The pregnant woman can seek to clarify her autonomous decision based on inadequate normative models by adopting a hermeneutical stance that provides a depth of ethical meaning.

1.5a Covenant Relationship

The pregnant woman can interpret her developing relationship with her fetus from the beginning of pregnancy up to the point where maternal-fetal conflict occurs. Her interpretation of the relationship with her fetus is a hermeneutical approach or stance.[65] The hermeneutical stance can be based on the Judeo-Christian biblical covenant

relationships between God and humans. The pregnant woman can interpret her developing relationship with her fetus as a covenant relationship.

The Judeo-Christian covenant relationships of the Old Testament or Hebrew Bible between God and humans are a covenant of promise and a covenant treaty. The New Testament covenant relationship is established through Jesus' life, death, and resurrection. The maternal-fetal covenant relationship, like the biblical covenant relationships, is a unilateral covenant. Both the biblical and maternal-fetal covenant relationships are gracious, generous gifts to another without further conditions on the recipient. Both reflect God's love for humans and are based in faithfulness and fidelity.

The maternal-fetal covenant relationship can also be understood on a secular level. The above concepts and values of the biblical covenant relationships are also found in secular relationships, such as civil marriages and parent-child relationships. Therefore, the pregnant woman can interpret her developing relationship with her fetus as a secular covenant relationship.

1.5b Covenant, Personhood, and Consent

Marjorie Maguire, in the article "Personhood, Covenant, and Abortion", writes about a normative theological relationship approach to determining the beginning of personhood.[66] She bases it on the covenant relationship between God and Israel in Exodus. Personhood is conferred on Israel, according to Maguire, through "a completely free and gracious gift on the part of Yahweh."[67] When the pregnant woman decides to continue or accept her pregnancy, she makes a covenant, a free gift of herself, with the fetus as God did with Israel.[68] Maguire equates covenant with the nonreligious term consent. The pregnant woman consents to continue the pregnancy.[69] Establishing a

covenant relationship with the fetus or consenting to continue the pregnancy confers personhood on the fetus according to Maguire.[70]

But the hermeneutical stance of covenant relationship is not dependent on the personhood of the fetus. The covenant relationship is also more than consent. Consent is defined by Merriam-Webster dictionary as agreeing, giving one's assent or approval.[71] Unlike consent, covenant includes a commitment the pregnant woman makes to her fetus.

1.5c Ethics of Care

Interpreting the developing maternal-fetal relationship as an ethic of care is another hermeneutical stance the pregnant woman can adopt. According to Hilde Lindemann, an ethics of care requires "a caring relationship" in which one "cares about the person you care for."[72] Paying attention to the wants and needs of those cared for and to the particulars of each situation and individual are required.[73] Caring can result from obligation or duty based on one's role, relationships, or job.[74] Caring does not necessarily require any emotional attachment or an ongoing relationship with the one that is cared for.[75] Mothering is believed to be representative of an ethic of care. Mothering as care supports nurturing the growth of the fetus and protecting it from harm.

The covenant relationship, though sharing much with an ethics of care, goes beyond caring. The maternal-fetal covenant relationship is not the result of the pregnant woman's role or duty to her fetus. Love is not necessarily a component of care.[76] Love is not part of mothering as care. Care is not always continuously present in a relationship. Care does not necessarily involve all aspects of the one-cared-for's life.[77]

1.5d Covenant Relationship and Community

The hermeneutical stance of covenant relationship can be adopted to give meaning to the pregnant woman's relationship with the various communities she belongs to. God's covenant relationship at Sinai was between God and all the people of Israel as a community.[78] The pregnant woman and her fetus are a part of many communities, for example family, work, state, country, etc. The pregnant woman's individual covenant relationship with her fetus can be interpreted as a reflection of her covenant relationship with these communities. Likewise, the various communities can adopt a similar hermeneutical stance with the pregnant woman and her fetus. The community's decision to support the pregnant woman and her fetus is given a depth of ethical meaning by interpreting the relationship as a covenant relationship.

1.5e Physician-Patient Covenant Relationship

The relationship between the pregnant woman and her physician can also be interpreted as a covenant relationship. The covenant relationship goes beyond rules, duties, individual rights, and doing the right thing.[79] The covenant relationship is based in virtue, in being a good person.[80] Gift is at the heart of a physician-patient relationship as covenant, the same as the maternal-fetal covenant relationship. Faithfulness and fidelity are at the basis of both covenant relationships. Both transcend the self-interest and minimal requirements of the contractual model.[81]

1.5f Summary

The pregnant woman may not initially interpret the developing relationship with her fetus throughout her pregnancy as a covenant relationship based on her own previous

knowledge, experience, and expectations. When presented with the concept of covenant relationship, upon reflection, the pregnant woman may realize that a covenant relationship existed with her fetus throughout the pregnancy and choose to adopt this hermeneutical stance.

The hermeneutical stance of covenant relationship goes beyond interpreting covenant as consent and is not dependent on one's view of personhood of the fetus. Although an ethic of care has much in common with the hermeneutical stance, covenant relationship goes beyond an ethic of care. The hermeneutical stance can also be adopted by the various communities the pregnant woman and her fetus belong to.

1.6 Chapter Summary

The following is a summary of the chapters of this dissertation.

1.6a Chapter Two

Chapter two demonstrates the inconsistencies in legal normative approaches and theories used in resolving maternal-fetal conflict. The chapter begins with an analysis of abortion law and how it is interpreted by the courts when ruling on cases of forced cesarean section. Restrictions on pregnant women's advanced directives and living wills, federal and state fetal homicide laws, and federal fetal research laws and the status these laws give to the fetus over the pregnant woman's liberty rights is explored.

1.6b Chapter Three

Chapter three discusses inconsistencies in philosophical normative theories applied to situations of maternal-fetal conflict. The inconsistencies between the four bioethical principles of respect for autonomy, justice, beneficence, and nonmaleficence

are examined. The chapter also looks at duty theories, which lead some philosophers to believe a pregnant woman has duties to her fetus as her future child. Kant's moral theory is analyzed as to the pregnant woman's moral obligation to her fetus.

1.6c Chapter Four

Chapter four examines inconsistencies between professional medical organizations and obstetrician's views on maternal-fetal conflict. Differences in how physicians and professional medical organizations view the fetus as a patient and the indications for cesarean section and how these contribute to their positions on maternal-fetal conflict are explored.

1.6d Chapter Five

Chapter five examines inconsistencies in religious moral teachings used to resolve maternal-fetal conflict. The status of the fetus in Catholicism, Judaism, and Islam, along with teachings on abortion is discussed. How religious moral teachings guide the pregnant woman's autonomous decision-making is analyzed.

1.6e Chapter Six

Chapter six first considers legal contracts as a possible alternative common normative theory for resolving maternal-fetal conflict. The concept of viewing the maternal-fetal relationship as a contractual relationship as insufficient to provide common ground for all involved parties is demonstrated.

The concept of hermeneutical stance is defined. The hermeneutical stance of covenant relationship is discussed, along with how the pregnant woman can interpret the

developing relationship with her fetus throughout her pregnancy as a covenant relationship to give ethical meaning to her autonomous decision.

Other interpretations of the maternal-fetal relationship, including covenant as personhood and an ethic of care, are compared to the maternal-fetal covenant relationship. The adoption of the hermeneutical stance of covenant relationship by the community and physician to understand their relationship with the pregnant woman and her fetus are presented.

The chapter ends with examples of clinical situations that fit the dissertation's case of maternal-fetal conflict. How to apply the hermeneutical stance and inconsistent normative theories and approaches to these clinical situations is shown.

1.6f Chapter Seven

Chapter seven begins with a review of the dissertation question and why the normative theories and approaches do not provide common ground for all involved to resolve a situation of maternal-fetal conflict. The pregnant woman adopting the hermeneutical stance of covenant relationship to give ethical meaning to her autonomous decision based on the inconsistent normative theories and approaches is reviewed. Limitations of the dissertation are discussed. Implications of the normative theories and approaches and the adoption of the hermeneutical stance for maternal-fetal conflict on policy, research, and education are presented.

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Chapter 2

The Fetus and The Law

2.1 Introduction

The chapter will focus on how the law views the fetus on both a state and federal level. How the courts balance the pregnant woman's liberty rights with the state's interest in protecting the potential life of the fetus is examined. Federal abortion laws and cases, beginning with Roe versus Wade, along with state and federal cases involving court-ordered or forced Cesarean sections are discussed. The cases are used to illustrate the courts' evolving views on this issue, starting with earlier rulings in favor of protecting the life of the fetus to later rulings upholding the pregnant woman's liberty rights. The chapter also looks at inconsistencies in the law concerning the pregnant woman's liberty rights versus the state's interest in preserving life and the status given to the fetus in pregnancy provisions of some state's advance directives laws, federal research laws, and federal and state fetal homicide laws.

2.2 Abortion Laws

Federal abortion laws in the United States established and upheld the pregnant woman's right to an abortion prior to the viability of the fetus. The right was initially based in the pregnant woman's right to privacy and then later in liberty. The laws also established that the fetus is not a person under the United States Constitution. Despite these findings, the courts have weighed the pregnant woman's rights against the state's interest in protecting the potential life of the fetus. A few of these cases are discussed, along with their application to situations of maternal-fetal conflict.

2.2a Roe versus Wade

The discussion of the legal aspects of maternal-fetal conflict begins by looking at a few key components of the 1973 United States Supreme Court case Roe v. Wade on abortion. Roe v. Wade was cited by state and federal courts in decisions involving forced cesarean sections. In Roe v. Wade, the United States Supreme Court ruled that a pregnant woman has a right to decide whether to have an abortion based in privacy as found in the liberty right of the Fourteenth Amendment.[1] The Court also ruled that state laws prohibiting abortion violated the Due Process Clause of the Fourteenth Amendment.[2] However, the Court ruled that this right is not absolute and State interests must also be considered. The State interests were defined as the protection of health, medical standards, and potential life.[3] States have an interest in protecting the life and health of the pregnant woman and the potential life of the fetus as it grows.[4]

The Supreme Court in Roe v. Wade discussed the State's interest in protecting prenatal life as it historically related to abortion. They stated that some based this on the belief that life begins at conception. The belief leads to the claim that the interests of the

embryo or fetus are primary except if the pregnant woman's life is in danger.[5] However, the Court believed "in assessing the State's interest, recognition may be given to the less rigid claim that as long as at least potential life is involved, the State may assert interests beyond the protection of the pregnant woman alone."[6]

The court also considered whether the fetus is a person with rights protected under the United States Constitution. The appellee and some amici in the Roe v. Wade case argued:

> the fetus is a "person" within the language and meaning of the Fourteenth Amendment. In support of this, they outline at length and in detail the well-known facts of fetal development. If this suggestion of personhood is established, the appellant's case, of course, collapses, for the fetus' right to life would then be guaranteed specifically by the Amendment. The appellant conceded as much on reargument. On the other hand, the appellee conceded on reargument that no case could be cited that holds a fetus is a person within the meaning of the Fourteenth Amendment.[7]

In his Opinion of the Court, Justice Blackmun writes that "the constitution does not define 'person' in so many words."[8] He notes the places where person is used in the constitution. He then points out that person in these places applies post-natal, not pre-natal.[9] The Court, based on this, concluded "that the word 'person', as used in the Fourteenth Amendment, does not include the unborn."[10]

The Supreme Court also addressed the question of when does life begin. The state of Texas argued that life begins at conception and the state had a compelling interest in protecting life from conception on.[11] Justice Blackmun articulates the Court's opinion:

> We need not resolve the difficult question of when life begins. When those trained in the respective disciplines of medicine, philosophy, and theology are unable to arrive at any consensus, the judiciary, at this point in the development of man's knowledge, is not in a position to speculate as to the answer.[12]

The Court believed that even if a theory on the beginning of life is adopted by a state, this cannot override the rights of the pregnant woman.[13]

Based on the above, the Court in Roe v. Wade established the following guidelines for abortion:

> (a) For the stage prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician.
> (b) For the stage subsequent to approximately the end of the first trimester, the State, in promoting its interest in the health of the mother, may, if it chooses, regulate the abortion procedure in ways that are reasonably related to maternal health.
> (c) For the stage subsequent to viability, the State, in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.[14]

Some courts have cited part (c), the state's interest in preserving the fetus' potential life, when ruling on cases of maternal-fetal conflict. According to Patricia King and Judith Areen, "nothing in Roe suggests that all legal protection is foreclosed merely because a fetus is not a 'person' as that term is used in the Constitution."[15] Roe also made it clear that pregnant women do not have exclusive control over their bodies.[16] King and Areen believe Roe "does not support a pregnant woman's refusal to cooperate with efforts to benefit her fetus."[17] But they also point out that although Roe may not support the pregnant woman's interest, the pregnant woman still has constitutional rights such as due process and bodily integrity.[18]

In Roe v. Wade, the Court weighed these two competing rights. The Court established a practice of balancing these two interests that some state and federal courts used when ruling on cases involving maternal-fetal conflict. However, these courts were not always consistent in doing this or following the trimester guidelines established by

Roe. Not all state courts see this part of Roe v. Wade (c) as providing protection to the fetus over the objections of the pregnant woman. The lack of consistency is illustrated later in this chapter by an examination of four legal cases of maternal-fetal conflict. One reason for this may be that part (c) is phrased "the State"… "if it chooses."[19] The Court does not say the state must regulate or proscribe abortion. The phrasing appears to give leeway to various interpretations by the court, leading to inconsistencies in rulings concerning forced cesarean sections.

Also, the state's interest in the health and life of the pregnant woman is considered in Roe. The Court provided clear guidelines concerning this. The only absolute right, according to the trimester guidelines, is the health and life of the pregnant woman. After viability, the pregnant woman's health and life take precedence over the fetus' life. But this part is not relevant in a case of maternal-fetal conflict as outlined in this dissertation. The pregnant woman's life is not endangered. Also, the state and federal courts do not cite this part of Roe in cases of forced cesarean sections. Perhaps this is because of the difference between a pregnant woman not being denied access to a desired procedure to save her life versus being compelled to undergo a procedure she does not desire to save her life or that of another.

2.2b Planned Parenthood of S.E. Pa. v. Casey

The 1992 United States Supreme Court case Planned Parenthood of Southeastern Pennsylvania v. Robert P. Casey involved the constitutionality of five provisions of the Pennsylvania Abortion Control Act of 1982.[20] The Court concluded in Casey:

> The essential holding of Roe v. Wade should be retained and once again reaffirmed. It must be stated at the outset and with clarity that Roe's essential holding, the holding we reaffirm, has three parts. First is a

> recognition of the right of the woman to choose to have an abortion before viability and to obtain it without undue interference from the state. Before viability, the State's interests are not strong enough to support a prohibition of abortion or the imposition of a substantial obstacle to the woman's effective right to elect the procedure. Second is a confirmation of the State's power to restrict abortions after fetal viability, if the law contains exceptions for pregnancies which endanger a woman's life or health. And third is the principle that the State has legitimate interests from the outset of the pregnancy in protecting the health of the woman and the life of the fetus that may become a child.[21]

The justices also wrote:

> The woman's right to terminate her pregnancy before viability is the most central principle of Roe v. Wade. It is a rule of law and a component of liberty that we cannot renounce.[22]

The Court ruled that a pregnant woman's right to an abortion was found in the liberty interest protected under the Due Process Clause of the Fourteenth Amendment, as opposed to basing it in privacy as in the Roe decision.[23] They believed the Constitution protects liberty rights from the state.[24] The Court also upheld protecting the life and health of the pregnant woman at all stages of pregnancy.

Besides the pregnant woman's right to an abortion, the justices also reaffirmed the ability of the state to restrict abortions once the fetus is viable provided an exception exists to protect the pregnant woman's life and health.[25] The Court's opinion states:

> Yet it must be remembered that Roe v. Wade speaks with clarity in establishing not only the woman's liberty but also the State's 'important and legitimate interest in potential life.' Roe, supra, at 163. That portion of the decision in Roe has been given too little acknowledgment and implementation by the Court in its subsequent cases…[26]

The Court did away with Roe's trimester framework. Instead, the Court now drew the line for choosing abortion at viability.[27] In fact, according to the Court, "in some broad sense it might be said that the woman who fails to act before viability has consented to the state's intervention on behalf of the developing child."[28] However, the

Court did not give a strict point at which viability occurred and recognized it may change over time as medical developments change.

The Court found that states can enact laws to make sure pregnant woman's choices are thoughtful and informed, with time to do so. However, states cannot impose undue burdens on the pregnant woman's ability to obtain an abortion. According to the Court, "the right recognized by Roe is a right 'to be free from unwarranted governmental intrusions into matters so fundamentally affected a person as the decision whether to bear or beget a child."[29] The Court held "the undue burden standard is the appropriate means of reconciling the State's interest with the woman's constitutionally protected liberty."[30] Undue burden was defined as state laws that put substantial obstacles that keep woman from obtaining an abortion.[31] If this part of Casey is applied to cases of maternal-fetal conflict, compelling a pregnant woman to undergo a cesarean section that she previously declined can be interpreted as placing an undue burden on her. Balancing the interests of the pregnant woman and the fetus favors the pregnant woman's liberty rights according to undue burdens.

As in Roe, the United States Supreme Court weighed the rights of the pregnant woman with the state's interest in preserving the potential life of the fetus. Once again, the pregnant woman's rights are not absolute even though the fetus is not a person under the Fourteenth Amendment. Casey appears to emphasize the State's interest in protecting the fetus after viability. Since the Court did not define viability at a specific point or week of pregnancy and acknowledged that the definition can change, the point in a fetus' development at which the State can protect the fetus can become earlier in pregnancy.

Viability may also be subject to the pregnant woman's location and availability of tertiary medical centers and specialized care. If used by a court in a case of maternal-fetal conflict, the courts can possibly choose the state's interests in the fetus' life over the liberty interests of the pregnant woman earlier and earlier in pregnancy. The emphasis on the state's interest after viability when applied to forced cesarean section cases appears to go counter to the use of the undue burden standard for balancing these two competing interests.

2.2c Gonzales v. Carhart

The April 2007 United States Supreme Court case Gonzales, Attorney General v. Carhart, et al. concerned the Partial Birth Abortion Ban Act of 2003. The stated purposes of the Act are to protect "innocent human life from a brutal and inhumane procedure" and to protect the ethics and integrity of the medical profession.[32] The Court ruled that the Act, which banned the specific abortion procedure known as partial birth abortion used in the later stages of pregnancy, was constitutional. The Court based its opinion primarily on Casey and Roe.

In the opinion, the Court writes that "Casey, in short, struck a balance. This balance was central to its holding."[33] The balance the Court referred to in Casey was between the state not being able to prohibit abortions or place undue burdens or obstacles on women trying to obtain an abortion before viability and the state's respect for potential life.[34] The Court stated that Casey reaffirmed "the government may use its voice and its regulatory authority to show its profound respect for the life within the woman."[35] Included is the state regulation of the medical profession.[36] The Court also believed "that respect for human life finds an ultimate expression in a mother's love for her child."[37]

However, as Justice Ginsberg put in her dissenting opinion, the Court, in all cases, always requires abortion laws to safeguard a woman's health at any stage of pregnancy. Included are safeguards for when the pregnancy itself is a threat to the mother's health and also when the threat is from the procedure used to perform the abortion.[38] The ruling upholds the balancing of the pregnant woman's liberty rights with the state's interest in the fetus' life as previously established in Roe and Casey. The state interest in protecting fetal life after viability was again emphasized.

2.2d Summary

These three United States Supreme Court cases concerning abortion law set forth several important principles. First, the pregnant woman's liberty right based in the Due Process Clause of the Fourteenth Amendment to have an abortion if desired. Second, the liberty right is limited by the State's interest in protecting the potential life of the fetus. Courts may balance the pregnant woman's liberty rights and the State's interest in the fetus. Third, viability is the point determined by the Court when the fetus' interests can be protected by the state. However, the Court recognized that the point at which a fetus is viable can change over time, resulting in an earlier point in pregnancy at which the fetus can be protected. Fourth, of ultimate importance over the above principles is the protection of the life and health of the pregnant woman at all stages in pregnancy.

These principles are applied by state and federal courts when confronted with a case concerning forced cesarean section. However, courts are not consistent in the interpretation and application of these principles as established and reaffirmed in Roe, Casey, and Gonzales.

2.3 Forced or Court Ordered Cesarean Section Cases

When cases of maternal-fetal conflict are brought before a court, the court must weigh, as in the above abortion cases, the state's interest in protecting future life versus the pregnant woman's liberty rights. As discussed later in this chapter, this state interest is one of four state interests that are strongest when there is a better prognosis and less bodily invasion of the patient. The four interests as set out by the United States Supreme Court are preserving life, protecting innocent third party interests, preventing suicide, and maintaining the ethical integrity of the medical profession.[39]

Some cases of maternal-fetal conflict involve forced cesarean sections. Forced cesarean sections are court-ordered cesarean sections.[40] Physicians and/or hospital administrators request and successfully obtain a court order to perform a cesarean section on a pregnant woman who refused the surgery.[41] At least eleven state courts ordered women to undergo a cesarean section that they previously refused, as opposed to delivering vaginally.[42] Four cases of maternal-fetal conflict resulting in a request to the court for a forced cesarean section and their outcomes are examined here. Differences in how the state and federal courts weighed the state's interests versus the pregnant woman's liberty rights are examined.

2.3a Jefferson v. Griffin Spalding County Hospital Authority

The January 1981 case Jessie Mae Jefferson v. Griffin Spalding County Hospital Authority et al. was the first published appellate court decision of a court-ordered cesarean section.[43] The case was also the first time a state Supreme Court upheld a lower state court ruling, Juvenile Court and Superior Court of Butts County, requiring a pregnant woman to undergo a cesarean section that she refused.[44]

Jesse Mae Jefferson was thirty nine weeks pregnant and was receiving prenatal care. She was diagnosed with a complete placenta previa and her obstetrician recommended a cesarean section.[45] A complete placenta previa is when the placenta completely covers the cervix. When labor and cervical dilatation occur, the placenta separates from the cervix, resulting in bleeding and hemorrhage. Mrs. Jefferson's obstetrician testified that the fetus had a ninety nine percent chance and Mrs. Jefferson had no more than a fifty percent chance of dying with a vaginal delivery, but both would survive a cesarean section.[46] Despite these facts, Mrs. Jefferson refused the cesarean section for religious reasons. She also refused a blood transfusion.[47] The hospital then sought court intervention to force Mrs. Jefferson to undergo the cesarean section. The question before the court as stated in the case was "whether this unborn child has any legal right to the protection of the Court."[48]

The Superior Court of Butts County initially ruled that since the fetus was fully viable, Mrs. Jefferson was required to undergo any necessary medical procedure to save the fetus' life if she voluntarily presented to the hospital.[49] The next day, the Georgia Department of Human Resources petitioned the court and was granted temporary custody of the fetus and the authority to make all decisions concerning the fetus. Included was the authority to consent to a cesarean section. The court ordered Mrs. Jefferson to undergo an ultrasound. If the placenta previa was present, the court ordered her to have a cesarean section. The court based its decision on the state's duty to protect the life of a viable fetus outweighing the intrusion into the lives of Mr. and Mrs. Jefferson. The Georgia Supreme Court upheld the Superior Court's ruling.[50] However, Mrs. Jefferson's placenta moved

away from the cervix and she delivered vaginally without any harm to her or her child. The court ordered cesarean section was not needed.[51]

Justice Hill and Justice Smith of the Georgia Supreme Court based the state's interest in preserving the life of the fetus in Roe v. Wade. Justice Hill wrote "the Supreme Court has recognized an interest in protecting the lives of unborn, viable children (viability usually occurring at about 7 months, or 28 weeks)."[52] Justice Hill acknowledged the competent adult's right to refuse treatment, but believed the fetus' right to life outweighed the mother's right to refuse treatment for religious reasons.[53]

In this case, both the Superior Court of Butts County and the Georgia Supreme Court followed Roe in their rulings. The case occurred eleven years before the Casey decision. Both courts were guided by part (c) in Roe which allows the State to regulate and proscribe abortion to promote the potential life of the fetus. The exception to this is protecting the pregnant woman's life and health.[54]

Even though Mrs. Jefferson's physician told the court that performing the cesarean section would save both Mrs. Jefferson and her fetus' life, the Hospital Authority sought to protect only the life of the fetus and the courts ruled accordingly. The courts never stated their rulings were meant to protect Mrs. Jefferson's life. Both courts balanced the state interest in protecting the viable fetus against the liberty rights of the pregnant woman, concluding that the fetus' right to life was greater. The courts, however, did not consider that it is impossible to physically grant custody of the fetus to anyone besides the pregnant woman as the fetus is inside the pregnant woman. To do so one must also give physical custody of the pregnant woman to another, in this case the Georgia

Department of Human Resources. Once again the state's interest in the fetus was favored over the liberty rights of the pregnant woman.

2.3b In Re A.C.

The thinking of appellate courts shifted away from favoring the state interest in preserving potential life over the pregnant woman's rights in 1990 with the case of In Re A.C. in the District of Columbia Court of Appeals. The case is the one most often cited in regards to court-ordered cesarean sections.[55]

In Re A.C. began on June 9, 1987. The case involved a pregnant woman with a history of cancer since she was thirteen years old. When she was twenty five weeks pregnant, she had an inoperable recurrence of the cancer in her lungs and was hospitalized. At that point in time, A.C. stated that she really wanted to have her baby.[56] However, her medical condition subsequently deteriorated and she was considered terminal. A.C. chose to start palliative treatment for her own comfort and to try to get to twenty eight weeks of pregnancy when the fetus would have a better chance of survival.[57] She was aware of the fact that the palliative care did involve some risks to the fetus. A.C., twenty six and a half weeks pregnant, now was equivocal in her response as to whether she wanted to have the baby, but consented to being intubated later the same day for respiratory difficulties.[58]

The hospital then petitioned the trial court of the District of Columbia to order A.C. to have a cesarean section. An emergency hearing was held the next day at the hospital.[59] Testimony from physicians informed the court that A.C. would probably die within twenty four hours and the fetus had a fifty to sixty percent chance of survival if delivered before then.[60] A.C.'s physician said she was on a ventilator, heavily sedated,

and unable to converse. A.C.'s mother and physician stated A.C. would not want the cesarean section before twenty eight weeks.[61]

The court believed it was not clear whether A.C. wanted the child to live. Since the fetus was viable, the state believed it had an interest in protecting human life and ordered a cesarean section to be done.[62] A.C. regained consciousness and was advised of the court's ruling. Her physician asked her if she agreed to the cesarean section, even though she might die. A.C. said yes.[63] However, when her doctors, husband, and mother later asked her the same question, A.C. stated she did not want the cesarean section. The court believed A.C.'s wishes still were not clear and again ordered her to undergo the cesarean section.[64] A.C.'s lawyer sought a stay which was denied by three members of the District of Columbia's Court of Appeals.[65] A.C. underwent the cesarean section. The baby lived a few hours and A.C. lived for two days after the cesarean section.[66]

A couple months later the entire District of Columbia Court of Appeals decided to hear the case. The court wrote:

> We are confronted here with two profoundly difficult and complex issues. First, we must determine who has the right to decide the course of medical treatment for a patient, who, although near death, is pregnant with a viable fetus. Second, we must establish how that decision should be made if the patient cannot make it for herself - more specifically, how a court should proceed when faced with a pregnant patient, in extremis, who is apparently incapable of making an informed decision regarding medical care for herself and her fetus. We hold that in virtually all cases the question of what is to be done is to be decided by the patient – the pregnant woman – on behalf of herself and the fetus. If the patient is incompetent or otherwise unable to give an informed consent to a proposed course of medical treatment, then her decision must be ascertained through the procedure known as substituted judgment. Because the trial court did not follow that procedure, we vacate its order and remand the case for further proceedings.[67]

The court recognized all individuals' right to refuse or accept medical treatment, even when incompetent, along with the duty of a pregnant woman to her fetus. The Court of Appeals believed it could not determine if A.C. was competent, what her wishes were concerning the cesarean section, and concluded from examining the court record that the trial court never determined if she was competent.[68] The court stated:

> We hold, however, without a competent refusal from A.C. to go forward with the surgery, and without a finding through substituted judgment that A.C. would have consented to the surgery, it was error for the trial court to proceed to a balancing analysis, weighing the rights of A.C. against the interest of the state.[69]

In Re A.C. occurred from 1987-1990. Once again, this was before Casey and Gonzales. Even though the trial court of the District of Columbia and the partial District of Columbia Court of Appeals recognized the state's interest in protecting potential human life and balanced this against the liberty rights of the pregnant woman, neither court mentioned Roe as the reason for their decisions. Despite this, these decisions followed the rulings in the Jefferson case and essentially also followed part (c) of Roe. The courts favored the viability of the fetus, even though the fetus' chances of survival were 50-60%.

When the entire District of Columbia Court of Appeals vacated the order and remanded the case for further proceedings, the court did not refer to Roe, but did state that balancing the state's and A.C.'s interests was the wrong approach.[70] The court ruled that A.C.'s liberty rights were primary and that her wishes should be carried out when known, even when she was incompetent, through substituted judgment.[71] The ruling was the opposite of the previous court rulings in this case and in Jefferson. Consistency in the court's rulings was no longer present. Even though the entire Court of Appeals did not

cite Roe, this ruling goes along with part (c) of Roe that states "if" the state chooses to promote its interest in protecting the fetus' life. The court in this case did not choose to protect the fetus' life.

2.3c Doe v. Doe

Similar to the entire District of Columbia Court of Appeals ruling in In Re A.C., based on the patient's bodily integrity and right to decide to accept or decline medical treatment, is the case of Baby Boy Doe v. Mother Doe, Appellate Court of Illinois in 1993. According to Presiding Justice DiVito, "this case asks whether an Illinois court can balance whatever rights a fetus may have against the rights of a competent woman to refuse medical advice to obtain a cesarean section for the supposed benefit of her fetus."[72]

The case involved Mrs. Doe who at thirty five weeks of pregnancy was advised by a perinatologist, who is an obstetrician specializing in high risk pregnancies, to preferably have a cesarean section or be induced for a vaginal deliver due to placental insufficiency which resulted in a lack of oxygen to the fetus.[73] The lack of oxygen would adversely affect the fetus' growth and development. Mrs. Doe was receiving prenatal care throughout the pregnancy. Mrs. Doe refused delivery either way based on religious reasons. Her husband agreed. According to the case, "instead, giving her abiding faith in God's healing powers, she chose to await natural childbirth."[74] About two weeks later Mrs. Doe was again examined by two obstetricians who advised immediate delivery by cesarean section due to the fetus' condition worsening. Mrs. Doe and her husband were told without the cesarean section the fetus would die or be born "severely retarded."[75] She again refused due to religious beliefs.[76]

That same day, the Cook County State's Attorney office, at the request of Mrs. Doe's perinatologist and the hospital, petitioned the Juvenile Court for custody of the fetus.[77] An emergency hearing was held later that day before a judge of the appellate court and then the next day with a three judge panel.[78] The majority ruled that the court lacked jurisdiction as the circuit court had not yet ruled on the case and that ordering a cesarean section would violate Mrs. Doe's constitutional rights. The circuit court denied the state's request for an injunction to order Mrs. Doe to undergo the cesarean section.[79] The court and all involved believed Mrs. Doe was competent.[80] The circuit court believed there was no "statutory or case law to support justifying the intrusive procedure requested herein by way of a court order against a competent person."[81] The ruling was appealed immediately to the Illinois Appellate Court, which affirmed the circuit court's ruling.[82] The Illinois Supreme Court and the United States Supreme Court both denied motions of appeal.[83]

Mrs. Doe delivered a healthy baby vaginally a couple weeks later. However, the ACLU petitioned the appellate court for a written opinion since this situation most likely would occur again.[84] The written opinion was delivered in 1994. The appellate court stated that balancing a viable fetus' rights against those of the mother should not be done by the court. Instead, the appellate court ruled a competent woman's decision "in refusing medical treatment as invasive as a cesarean section during her pregnancy must be honored, even in circumstances where the choice may be harmful to her fetus."[85] The court cited the right of a competent adult to refuse treatment on religious grounds or religious liberty even when she is pregnant.[86] The court also cited decisions in which courts have refused to force one individual to undergo a medical procedure for the benefit

of another; held that the four state interests are not violated by the ruling; the fact that Thornberg v. American College of Obstetricians and Gynecologists established "that the woman's health is always the paramount consideration; any degree of increased risk to the woman's health is unacceptable;" and that Roe allows states to prohibit abortion after viability except if the mother's life or health is at risk, but "does not translate into the proposition that the state may intrude upon the woman's right to remain free from unwanted physical invasion of her person when she chooses to carry her pregnancy to term."[87]

The Doe case occurred after Roe and Casey. The rulings in Doe held that a competent pregnant woman's right to refuse treatment was primary. The appellate court, like the entire District of Columbia Court of Appeals, believed that balancing the state's interests in the fetus' life with the liberty rights of the pregnant woman was not appropriate. However, the Illinois Appellate Court did refer to Roe, arriving at a different interpretation of part (c) of Roe from that in the Jefferson case. The Illinois court also referred to the part of Roe that protects the life or health of the pregnant woman. However, in this case, the pregnant woman's life and health was not at risk like in Jefferson. The court interpreted undergoing the cesarean section as putting her health and life at greater risk than a vaginal delivery. But the court ignored Casey which did say that a pregnant woman who does not act before viability consents to intervention by the State in the interests of the child.[88] Consistency in the court's interpretation of Roe and its application to cases of forced cesarean sections was not present.

2.3d Pemberton v. Tallahassee Memorial Regional Medical Center

Despite the shift from the courts favoring the right of a viable fetus to be born alive and the state's interest in preserving life, to upholding the pregnant woman's right to accept or refuse medical treatment, in October 1999 a federal court shifted back to favoring the fetus. The case of Laura L. Pemberton v. Tallahassee Memorial Regional Medical Center was heard in the United States District Court, N.D. Florida, Tallahassee Division.[89]

In 1995, Mrs. Pemberton had a cesarean section performed through a vertical incision in her uterus. In 1996, she was pregnant again. She desired a vaginal delivery but could not find a physician who would do so because of her previous uterine scar. There was a high risk for uterine rupture with labor because of the scar, which could be fatal to both her and the fetus.[90] Mrs. Pemberton then decided to attempt a vaginal delivery at home attended by a midwife with no physician or hospital back-up.[91]

Mrs. Pemberton initially presented to the hospital emergency room, requesting intravenous fluids for treatment of dehydration after laboring for over a day at home. However, after she received the intravenous fluids, she wanted to return home to continue laboring.[92] The physician refused to agree to this plan, advising Mrs. Pemberton that she needed to have a cesarean section. Mrs. Pemberton then left the hospital against medical advice.[93] The hospital's attorney contacted the Florida circuit court judge and a hearing was held at the hospital. The physicians testified that "there was substantial and unacceptable risk of death" without the cesarean section. The text of the case states "Dr. Thompson, Brickler, and O'Bryan testified unequivocally that vaginal birth would pose a substantial risk of uterine rupture and resulting death of the baby."[94] The judge granted

the hospital's request for a court-ordered cesarean section and ordered Mrs. Pemberton brought to the hospital.[95] However, the reasoning for the judge's order is not given. Mrs. Pemberton was returned to the hospital against her will and another hearing was held where she stated her wishes to have a vaginal delivery. However, the judge upheld the order for her to undergo the cesarean section. Mrs. Pemberton underwent the cesarean section without any complications to her or her baby.[96]

Mrs. Pemberton did not appeal the circuit court order, but later sued the hospital in federal court for violation of her constitutional rights, right to procedural due process, common law negligence, and false imprisonment.[97] The federal court ruled in favor of the hospital. The court believed Mrs. Pemberton's constitutional rights were outweighed by the state's interest in preserving the viable fetus' life. The court based this in Roe v. Wade.[98] The court believed that ordering a cesarean section on Mrs. Pemberton for a desired child was not as great an imposition as Roe forcing a pregnant woman to bear an undesired child.[99] The court also believed that since Mrs. Pemberton desired to have the baby and since no physician would agree to a vaginal delivery given her history that this case was "extraordinary and overwhelming" and the fetus' interests were greater than the mother's right to make decisions concerning medical care.[100] The federal court also ruled Mrs. Pemberton's right to due process was not violated, the physicians and hospital were not negligent, and she was not falsely imprisoned.[101]

The ruling in Pemberton is similar to those in Jefferson and the initial ruling in In Re A.C. The federal court, like the Supreme Court of Georgia, cites part (c) of Roe as the basis for putting the State's interests in the fetus before the liberty interests of the pregnant woman. The ruling once again creates inconsistency as it goes counter to the

final ruling in In RE A.C. and the Doe rulings. The federal court in the case notes did acknowledge the Doe ruling, but stated that just because Illinois ruled in favor of the pregnant woman does not mean other states must do so.[102] The statement also perpetuates the inconsistency seen in the court rulings on forced cesarean sections.

The federal court also wrote "to the extent Baby Boy Doe suggests a medical procedure can never be forced on a citizen even if the importance of the procedure clearly outweighs the intrusion on the citizen's interests, the court was simply wrong; states can and routinely do require such procedures as immunization of children, under appropriate circumstances."[103] But the federal court did not compare Doe or its ruling in Pemberton to the situation of the court forcing one person to undergo a procedure to benefit or save the life of another person, such as a parent for a child. Comparing these decisions to immunization of children is not adequate or equivalent as nothing is required of the parent except to take the child for an immunization. The parent is not required to actually undergo a procedure with the immunization of a child. Also, the degree of invasiveness with an immunization is minimal compared to a cesarean section.

The federal court, by basing its decision in part (c) of Roe, uses the same reasoning as the Superior Court of Georgia eighteen years earlier, limiting the pregnant woman's liberty. Like Jefferson, the court acknowledged the increased risk to the pregnant woman with a vaginal delivery, but did not give this as a reason for ordering the cesarean section. Although they did not state this, both courts recognized the pregnant woman's right to refuse a treatment even if it harms her, but did not believe this outweighed the state's interest in the fetus' life.

2.3e Summary

As shown above, the state and federal courts are not consistent in rulings on forced cesarean sections. The courts initially balanced the liberty rights of the pregnant woman against the state's interest in protecting the life of the fetus, ruling in favor of the fetus. Over time the courts shifted to rulings in favor of the pregnant woman's liberty rights. However, rulings once again shifted back to the balancing process in favor of the fetus.

The rulings create confusion for physicians and hospital administrators due to this lack of consistency and the federal court in Pemberton declaring that states do not have to follow a ruling protecting the pregnant woman's liberty rights in another state. They may not know whether or not they should turn to the courts when a situation of maternal-fetal conflict occurs if a pregnant woman declines a recommended cesarean section for the benefit of her viable term fetus. They also cannot be sure how the court will rule based on the above inconsistencies in cases of forced cesarean sections.

Courts are not an ideal route for resolving maternal-fetal conflict as seeking court orders destroys any trust a patient has in her physician and other health care providers, judges may need to make hasty, uninformed decisions, and patients may not be able to obtain appropriate and adequate legal counsel. All patients may not go along with the court's decision if required to have the cesarean section as Laura Pemberton did, putting the physicians and hospital staff in the position of operating on an unwilling patient.

2.4 Legal Principles

As illustrated in the above court cases, the underlying legal principles are the pregnant woman's rights of privacy, liberty, due process, and bodily integrity and the

state's interest in protecting and preserving the potential life of the viable fetus. As the cases show these legal principles come into conflict in cases of court-ordered cesarean section. Even though courts have ruled that non-pregnant individuals cannot be compelled to undergo a medical treatment or procedure to save the life of another, courts have compelled pregnant woman to undergo surgery for the sake of her fetus.

2.4a Liberty, Privacy, Due Process, and Bodily Integrity

The Fourteenth Amendment of the United States Constitution states in section one:

> No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.[104]

The state and federal courts base the legal principles of liberty and due process in this part of the Fourteenth Amendment. The Fourteenth Amendment Due Process Clause of the United States Constitution is also known as the Liberty Clause.[105]

Liberty is defined in Black's Law Dictionary as:

> 1. Freedom from arbitrary or undue external restraint, esp. by a government. 2. A right, privilege, or immunity enjoyed by prescription or by grant; the absence of a legal duty imposed on a person.[106]

Individual's liberty interests have been guaranteed in the Declaration of Independence, "all people have inalienable rights", the preamble of the constitution, and the Bill of Rights.[107] These liberty interests may only be limited by states, according to West's Encyclopedia of Law, "for a legitimate public purpose and only by means that are rationally designed to achieve that purpose."[108] The United States Supreme Court has ruled that "individual freedom may be restricted when necessary to advance a compelling

government interest, such as public safety, national security, or the protection of rights of others."[109] Freedom of religion is one of the liberties guaranteed by the above documents.

The idea of due process is originally from English common law, dating back to the Magna Charta in 1215 and was also found in the American colonies statutes in the 1600's.[110] Black's Law Dictionary states the Due Process Clause of the Fourteenth Amendment is "the constitutional provision that prohibits government from unfairly or arbitrarily depriving a person of life, liberty, or property."[111] Due Process is found in the United States Constitution in the Fifth and Fourteenth Amendments.[112] The Fifth Amendment Due Process Clause states "no person shall 'be deprived of life, liberty, and due process of law" and applies to the federal government.[113] The Fourteenth Amendment applies to states.[114]

Dawn E. Johnsen believes the United States Supreme Court emphasizes that "privacy is the right to make decisions free from state intrusion."[115] The state cannot interfere with a protected right or an individual's autonomous decision-making process.[116] The individual right to privacy, though not specifically mentioned in the United States Constitution, is derived from the Fourteenth Amendment Due Process Clause, specifically from the category of substantive due process, as opposed to procedural due process.[117] Substantive law creates, defines, and regulates rights while procedural law enforces the rights or if violated, seeks redress.[118]

In the 1920's, the United States Supreme Court began incorporating the Bill of Rights into the Fourteenth Amendment Due Process Clause. The action applied the Bill of Rights to state government also.[119] According to West's Encyclopedia of Law, in the 1960's, the Supreme Court "extended its interpretation of substantive due process to

include rights and freedoms that are not specifically mentioned in the constitution, but that, according to the Court, extend or derive from existing rights."[120] Included in this are the right of privacy, derived form the First, Fourth, and Ninth Amendments and originally established by the Supreme Court in Griswold v. Connecticut and later used as the basis for the Court's legalization of abortion in Roe v. Wade.[121] The Court views privacy as a liberty right even though it is not specifically enumerated in the Constitution and justifies it, as West's Encyclopedia of Law says:

> By stating that some rights are basic and fundamental, and that the government has a duty to protect those rights. It has held that the Constitution outlines a "realm of personal liberty which the government may not enter."[122]

The Court ruled that it must uphold and protect individual liberties even if the majority of its citizens disagree or if the act is not considered moral.[123]

Deborah Matieu points out that there are limits to liberty and privacy imposed on citizens by the state, such as speed limits, taxes, etc.[124] She believes that they are not "distinctly and uncontroversially delineated" and "are open to interpretation."[125] She defines liberty as "freedom from unwanted touching (or the right to bodily integrity); and the relevant aspect of privacy involves private decision making (or the freedom from unwanted intrusion by the state into one's intimate affairs)."[126] These rights are also derived from common law and the Ninth Amendment which recognizes, according to Matieu, "the Constitution does not enumerate all rights 'retained by the people."[127]

State and federal courts use these common law and constitutional rights of liberty, privacy, due process, and bodily integrity as the basis of their decisions that uphold the rights of fully-informed individuals to refuse or discontinue medical treatment, even if it is harmful to themselves or others. According to West's Encyclopedia of Law, "the

patient's legal right to refuse medical treatment has been grounded as well on the common law rights of bodily integrity, also called bodily self-determination, and on the liberty interest under the Due process Clause of the Fourteenth Amendment."[128]

Justice Cardozo, Court of Appeals of New York, wrote "every human being of adult years and sound mind has a right to determine what shall be done with his own body and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."[129] His statement was based on the common law right of bodily integrity.

Dawn E. Johnsen believes the United States Supreme Court "has described the 'right to be left alone' as 'the most comprehensive of rights and the right most valued by civilized man."[130] She goes on to say that:

> This right is particularly important when the state intervention involves a physical intrusion on an individual's body... The right to be free from government control of one's physical person has been described as the right to "personal privacy and dignity", "personal security", and "bodily security and personal privacy."[131]

Bodily integrity is defined by the United States Supreme Court as "a qualified right to be free of unwarranted bodily intrusions."[132] Bodily integrity is found "in the Fourth Amendment 'right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures."[133] Bodily integrity is used by courts to prohibit the government from forcing psychiatric drugs on patients, pumping stomachs to gain evidence, or ordering a competent individual to undergo surgery for his/her benefit or his/her family's benefit.[134] Courts never permit a major surgery without a suspect's consent to retrieve evidence if the surgery requires more than local anesthesia.[135] As Sarah Adams, et al. writes "the more serious the proposed governmental

intrusion on individual rights, the more stringent the due process requirements should be."[136]

The right to privacy is central to court rulings concerning reproduction and the family. As stated before, the right to privacy was established by the United States Supreme Court case of Griswold v. Connecticut in which the court abolished a law prohibiting the use of contraception by married couples.[137] The Court later applied privacy to other decisions concerning reproduction, marriage, family, and the raising of children.[138]

The right to privacy was also invoked by the New Jersey Supreme Court in the Karen Ann Quinlan case. The Court stated that Karen had a Constitutional right to privacy that could be protected by her legal guardian and honored by the Court, permitting her respirator to be removed.[139]

The United States Supreme Court wrote in Nancy Beth Cruzan v. Director, Missouri Department of Health, et al.:

> Before the turn of the century, this Court observed that "(n)o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."[140]

The Court also said that the patient not only has the right to consent to treatment but to refuse treatment.[141] According to the Court, "the principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions," but they also believed that liberty interests have to be balanced against relevant state interests.[142] The Court wrote that it has never based the right to refuse treatment in the constitutional right of privacy as states have done, such as

New Jersey with Quinlan, and believes this right instead lies in the liberty interest of the Fourteenth Amendment.[143]

Besides the individual's right to refuse treatment that is beneficial to one's self, the courts also applied these rights when an individual is asked to undergo medical treatment or a procedure for the benefit of someone else. The case of McFall v. Shimp, July 26, 1978, in the 10th Pennsylvania District, Allegheny County, involved one individual asking the court to force another individual to undergo a surgical procedure solely to benefit the first individual.[144] Robert McFall had aplastic anemia and needed a bone marrow transplant in an attempt to save his life. His first cousin David Shimp was the only donor match.[145] However, Shimp refused to be the donor. McFall went to court to compel Shimp to undergo testing and donate his bone marrow to McFall.[146] McFall based his case on an ancient English statute that was about 700 years old. He posed the question "in order to save the life of one of its members by the only means available, may society infringe upon one's absolute right to his bodily security?"[147]

The court's answer to this question was no. The court found that common law consistently ruled that one person is not legally obligated to act or aid another person to save his/her life or to rescue another person.[148] The court also ruled that our society's first principle, unlike others, is respect for the individual and that our government and society "exist to protect the individual from being invaded and hurt by another."[149] The court believed forcing Shimp to undergo the invasive procedure would change the very concept and principle upon which our society is founded. The court stated:

> To do so would defeat the sanctity of the individual, and would impose a rule which would know no limits, and one could not imagine where the line would be drawn.[150]

The individual rights of liberty, due process, privacy, and bodily integrity of the pregnant woman were upheld by the Illinois and the entire District of Columbia Appellate Courts when ruling on the question of forced cesarean sections. The rights of the pregnant woman were primary for these courts, even though potential harm to the fetus was possible. The appellate courts followed the thinking of the Shimp ruling that an individual cannot be compelled to undergo a procedure to save the life of another, even if the individual is the only one who can do so. The appellate courts also looked to previous court rulings which established that an individual has the right to determine what is done to her own body, including the right to consent to or refuse medical treatment.

2.4b State Interests

The courts ruled that the above discussed individual rights are not always absolute. Balanced against the individual's rights of privacy, bodily integrity, liberty, and due process are the state's interests. The United States Supreme Court in Cruzan, when discussing In re Quinlan, noted that the New Jersey Supreme Court balanced Karen's right to privacy against state interest. The New Jersey Supreme Court acknowledged "that the State's interests 'weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims."[151]

The United States Supreme Court also delineated the four state interests based on prior case law – preserving life, protecting innocent third party interests, preventing suicide, and maintaining the ethical integrity of the medical profession.[152] Of these four, the state interest in preserving life is the one considered by the courts in the previously discussed cases of court-ordered cesarean sections.

As to the other three state interests, preventing suicide does not apply in any of these cases. The state interest was never discussed by the courts in their rulings, except the Appellate Court of Illinois in the Doe case which ruled that none of the state interests were violated.[153] None of the pregnant women were trying to kill themselves. They declined surgery based on religious beliefs, the belief that surgery was not necessary to save the pregnant woman's and/or the fetus' life, or in an attempt to prolong gestation for the fetus' benefit and the pregnant woman's life in the case of In Re A.C. In all but In Re A.C., the pregnant women truly believed they and their fetuses would be fine without the cesarean section. They did not agree with their physicians views on the outcome of their pregnancies. They also were not trying to kill their fetuses.

Concerning the state interest in maintaining the integrity of the medical profession, the United States Supreme Court in Gonzales v. Carhart did say it is clear that the government "has a significant role to play in regulating the medical profession" for the purpose of maintaining the professions' ethics and integrity.[154] However, none of the courts invoked this state interest specifically as a reason for ordering the pregnant woman to undergo a cesarean section she had refused. None of the courts in these cases, except Doe, even discussed this state interest. The Appellate Court in Doe quoted the American Medical Association's policy of supporting the pregnant woman's decision.[155] The federal court in the Pemberton case did consider the question of whether the hospital and physicians involved acted negligently in forcing Mrs. Pemberton to have a cesarean section. The court determined they did not.[156]

The state interest of protecting innocent third party interests also was not a factor in any of the court-ordered cesarean section cases discussed. In no case did the court

consider any third parties involved. Protecting the interests of innocent third parties was defined by the Supreme Court of Pennsylvania in the case of In Re: Daniel Joseph Fiori, an Adjudged Incompetent; Appeal of: Commonwealth of Pennsylvania, Attorney General as "the primary focus is on whether the patient has dependents who would be left emotionally and financially bereft were the patient to refuse medical treatment."[157] None of the previously discussed cases, except Doe, took this fact into consideration in the court's ruling. However, the Doe court did not believe this was relevant.[158] In fact, in all four cases the patient's husband agreed with the patient's decision to refuse the surgery and was present at the court hearing. No mention was made of the effect the pregnant woman's refusal of surgery would have on her other children, if she had any. In at least the Pemberton case, it is known that the pregnant woman did have a small child. However, this issue was not considered by the court. No other third parties were identified or considered in any of the four cases.

The only state interest that was considered in these cases of court-ordered cesarean sections was the preservation of life, specifically the preservation of the life of the fetus. The courts weighed this against the pregnant woman's legal rights of liberty, privacy, due process, and bodily integrity, which they have stated are not absolute.

State interest is stronger when it is likely that an action will cause significant harm to the fetus or child.[159] But this interest weakens as harm and bodily intrusion to the pregnant woman or the parent increases.[160] The state interest in protecting fetuses from the actions of another that threaten the fetuses' lives was invoked by the courts to limit abortion in Roe v. Wade, Planned Parenthood v. Casey, and Gonzales v. Carhart. The state interest was also invoked by the courts in Jefferson v. Griffin and Pemberton v.

Tallahassee, and the initial ruling of the trial court and the partial appellate court in the case of In Re A.C. In all of the cases, protection and preservation of the life of the fetus from the actions of the pregnant woman that would harm the fetus was the concern of the courts, i.e. protecting the fetus from harm due to the action of a third party.

John Robertson believes that risks of surgery to the pregnant woman and benefits to the fetus must be weighed before invoking the state's interest to compel treatment.[161] He thinks this step should be undertaken only if a clear need exists. However, this creates the dilemma for physicians of following the pregnant woman's decision that may result in the fetus' death or operate on the pregnant woman against her wishes and risk assault and battery civil or criminal charges.[162] State statutes that prevent fetal abuse must be weighed against the privacy of the pregnant woman. The harm must be severe and likely to occur.[163]

Joel Jay Finer, in the article "Toward Guidelines for Compelling Cesarean Surgery: Of Rights, Responsibilities and Decisional Authenticity," makes an argument in support of state interests in preserving the life of the fetus and requiring the pregnant woman to undergo a cesarean section when needed.[164] He points out that a fetus needing a cesarean section is usually beyond viability and is about to be born and begin being a child.[165] He believes this "verge-of-birth-fetus" is different from a fetus which may be viable but not as far along in gestation and therefore deserves greater protection from the state.[166] For him, the only difference between the newborn and "verge-of-birth-fetus" is the fetus is still in the uterus. The age of the fetus gives the state the right to require "life-saving, handicap-preventing treatment" for the "verge-of-birth-fetus" the same as it

would for a newborn.[167] For Finer, gestational age is the determining factor in favoring the state interest in protecting potential life over the rights of the pregnant woman.

Finer's argument defines the point for invoking the state's interest in protecting the fetus' life much narrower than Roe or Casey. Finer uses "verge-of-birth" which can be interpreted as term which is 37 weeks. Roe and Casey use viability which as stated earlier can change with medical advancements and currently is around 23 - 24 weeks.

2.4c Summary

The pregnant woman's right to refuse treatment even at the expense of her fetus' life or health is based in individual liberty rights to be free from unwanted bodily invasion. These rights can be limited by government interests. One of these limiting interests is the state interest in preserving life, including the potential life of the fetus. The other three state interests are not invoked by courts in rulings concerning forced cesarean section.

2.5 Advance Directives and Pregnancy

As illustrated by the four court-ordered cesarean section cases discussed previously, there is no consistent view among the courts concerning the competing interests of the pregnant woman's rights and the state interest in preserving the potential life of her fetus. The inconsistency is also seen in advance directives and living wills concerning pregnant women. A majority of states completely or partially limit the pregnant woman's ability to determine her medical care and treatment through the use of advance directives unlike non-pregnant individuals.

2.5a Definition – Advance Directives

Advance directives are made by competent persons acting autonomously.[168] Advance directives consist of two parts – a durable power of attorney and a living will. A durable power of attorney, or proxy directive, is a document in which a person appoints a surrogate decision-maker to make the person's health care decisions when he or she cannot. The surrogate should act as the person would in that situation, if those wishes are known to the surrogate, using substituted judgment.[169] A living will is a document detailing what treatment an individual does or does not want if he or she is terminally ill or permanently unconscious and cannot make his or her own decisions concerning medical care and treatment.[170]

Even though the idea behind advance directives is for patients' wishes to be known and followed concerning their medical care and treatment when they are unable to communicate them, allowing the individual to still act autonomously, they may not be followed in every situation. Pennsylvania Advance Directive Law, under Legislative findings and intent, states:

> The General Assembly finds that all competent adults have a qualified right to control decisions relating to their own medical care. The right is subject to certain interests of society such as the maintenance of ethical standards in the medical profession and the preservation and protection of human life.[171]

Besides Pennsylvania, five other states, Florida, New Jersey, Michigan, Nebraska, and Delaware, mention the protection of state interests in their statutes or codes pertaining to advance directives. Florida's clause is similar to Pennsylvania, citing the interests of the society to protect life and the ethics of the medical profession.[172] Delaware's Code simply states in part 2502 Right of self-determination "an individual,

legally adult, who is mentally competent, has the right to refuse medical or surgical treatment if such a refusal is not contrary to existing public health law."[173] Nebraska's law declares the common-law and constitutional right of individuals to direct their medical treatment is subject to all four previously mentioned state interests.[174] Michigan's code in section 333.5660 part (c) states that the law does not "limit the ability of a court making a determination about a decision of a patient who has reduced life expectancy due to advanced illness to take into consideration the four state interests."[175] New Jersey Advance Directives for Health Care likewise has the clause in section 26:2H-54 d.

> The right of individuals to forego life-sustaining measures is not absolute and is subject to certain interests of society. The most significant of these societal interests is the preservation of life, understood to embrace both an interest in preserving the life of the particular patient and a related but distinct interest in preserving the sanctity of all human life as an enduring social value.[176]

The section then goes on to discuss the other three state interests.

2.5b Pregnancy Clauses

Despite the fact that only six states explicitly mention in their advance directive statutes the state and societal interest in preserving and protecting life, a majority of states invoke this state and societal interest when it comes to pregnant women and honoring their advance directives.

An examination of all fifty states and the District of Columbia's statutes pertaining to advance directives, which consist of living wills and health care surrogates or power of attorney and do-not-resuscitate orders show many variations when it comes to pregnant women. Eighteen state laws have no pregnancy restrictions in their statutes.

Of these, Michigan and New Jersey are the only two whose code includes a clause concerning state interests, but does not specifically apply the state interest in preserving and protecting life to a pregnant woman. New Jersey's law in section 26:2H-56 Advance directive for health care; execution part 4 includes the statement "a female declarant may include in an advance directive executed by her, information as to what effect the advance directive shall have if she is pregnant."[177] Arizona, in section 36-3262 Sample Living Will, gives an option for a person to initial (#3) to continue treatment if pregnant and the fetus can develop to the point of a live birth.[178] Maryland law, section 5-603 suggested forms for Powers and Rights of Health Care Agent in section F, gives an optional place for instructions for the agent if the woman is pregnant and also in the Treatment Preferences (Living Will) in section F is an optional place for wishes concerning treatment if the woman is pregnant.[179] The other fourteen state statutes make no mention of pregnancy in their advance directive laws or official forms. These states are Maine, Louisiana, Massachusetts, Mississippi, Tennessee, Vermont, Virginia, West Virginia, New Mexico, New York, California, Hawaii, North Carolina, and Wyoming. These eighteen states do not limit a pregnant woman's rights to determine her own medical care and treatment through the use of advance directives, even if it causes harm to the fetus.

At the other extreme, twelve states have a clause in their advance directive laws invalidating the advance directive if the patient is pregnant. There are no exceptions to this clause. Texas law also states that an out-of-hospital Do Not Resuscitate order is invalid if the patient is known to be pregnant.[180] Texas, Idaho, Oklahoma, Washington, and Wisconsin put in the state form that the advance directive is invalid or not effective if

the declarant is pregnant. The other seven states, South Carolina, Utah, Alabama, Connecticut, Indiana, Missouri, and Kansas, do not. None of these states include the clause concerning the state and societal interest in protecting and preserving life in their advance directives. But these twelve states place this state interest above the rights of the pregnant woman to determine her medical care and treatment.

Twelve other states have provisions in their advance directive laws essentially stating that treatment cannot be withheld or withdrawn from a pregnant woman if continuing life-sustaining treatment results in the live birth of the fetus. These states are Montana, Nebraska, Delaware, Nevada, Arkansas, Colorado, Illinois, Minnesota, Ohio, Rhode Island, Alaska, and Iowa. Only Nebraska's and Delaware's law include the clause on state interest in preserving and protecting life.[181]-[182] The pregnancy restriction is not included on any of the twelve states' recommended forms. Once again, the state interest in preserving and protecting potential life is given more weight than individual rights.

Five other states, Pennsylvania, Kentucky, South Dakota, North Dakota, and New Hampshire, place restrictions on the discontinuation of life-sustaining treatment of a pregnant woman unless 1.) the fetus will not develop and be born alive, 2.) continuing the pregnancy will cause physical harm to the woman, or 3.) she has severe pain which cannot be alleviated.[183] New Hampshire puts this restriction in the patient disclosure information.[184] The other four states' laws allow for a woman to say that she does not wish to have these restrictions apply if she is pregnant. Only Pennsylvania has the clause concerning the state interest in protecting and preserving life. None of these four states put the restrictions on their official form.

Georgia's restrictions in section 31-32-8 of its advance directive law require a physician to determine that a patient is not pregnant before following her wishes expressed in her living will to withhold or withdraw treatment.[185] However, the living will is not effective if it is determined that she is pregnant unless the fetus is not viable at that time and she has specifically indicated the living will is to be carried out even when pregnant.[186] She must initial the specific clause pertaining to this situation on the form.[187] Otherwise, life-sustaining treatment must be continued if she is pregnant.

Florida Code, which includes the clause about state interests in protecting and preserving life, does not allow a surrogate to withhold or withdraw life-sustaining treatment prior to viability of the fetus unless instructed otherwise by the individual or approved by the court.[188] The same restrictions apply to a surrogate's consent for abortion also.[189]

Texas advance directive law, in addition to pregnancy restrictions, does not allow a surrogate to consent to abortion.[190] Alaska's advance directive law also does not allow a surrogate to consent to abortion without a durable power of attorney for health care or another written instruction unless needed to preserve the life of the patient or serious health impairment.[191]

The District of Columbia and Oregon have no pregnancy restrictions except those pertaining to abortion. The District of Columbia allows a substitute decision-maker to consent to abortion if a court authorizes the procedure.[192] Oregon does not allow a surrogate to consent to abortion.[193]

Thirty three states and the District of Columbia place a state interest in preserving the fetus' potential life over a woman's right to determine her medical care and treatment

as established by the courts in the rights of liberty, bodily integrity, due process, and privacy. The state interest is not absolute in all of the states, as discussed above. There is a two to one majority in favor of state interests. Despite the fetus having no status as a person under the Fourteenth Amendment per Roe v. Wade,[194] two thirds of states give a status to the fetus that takes precedence in most cases over the written expressed wishes of the terminally ill or permanently unconscious pregnant woman concerning her health care and treatment and desires to withhold and withdraw treatment. Only six of these states include in their advance directive law the right of state interests to override individual rights. Also, only a small number of states place the information on pregnancy restrictions or options in the official state forms and declarations given to individuals. As with the previously discussed court rulings on forced cesarean sections, the states are not consistent or uniform as to their views on the individual rights of the pregnant woman and the state interest in preserving and protecting the potential life of the fetus.

In comparing the individual court cases examined previously and the advance directive statutes of the states where the cases occurred, it shows there are also inconsistencies in at least one case between the judicial and legislative branches. In Re A.C. took place in the District of Columbia. The final judicial decision of the Court of Appeals and the District's Health - Care Decision Act are consistent since the Health – Care Decisions Act places no restrictions on withholding and withdrawing treatment for a pregnant woman. Both allow for the pregnant woman's wishes to be followed even if she is no longer capable of making her own decisions. However, the initial rulings of the District of Columbia trial court and partial Court of Appeals ordering A.C. to undergo the cesarean section was not consistent with the advance directive law. Likewise, Florida's

and Georgia's legislative and judicial branches are consistent at the other end of the spectrum. Both put state interests in preserving potential life of the fetus over the liberty rights of the pregnant woman. Florida and Georgia are consistent in interpreting part (c) of Roe.

However, Illinois' legislative and judicial branches are not consistent. The legislature protects the state interests in preserving life by not allowing an advance directive to take effect if a patient is pregnant and continuing life-sustaining treatment can result in a live birth of the fetus.[195] In Baby Boy Doe v. Mother Doe, the Appellate Court of Illinois upheld a pregnant woman's right to refuse medical treatment even if it harms her viable fetus.[196]

2.5c Summary

The state legislatures, in formulating the pregnancy part of their advance directive laws, do not include their reasons for supporting either the pregnant woman's liberty rights or the state interest in protecting the life of the fetus. There is no way of knowing if they considered Roe or Casey or how their state courts ruled in cases of maternal-fetal conflict.

The inconsistencies concerning pregnant woman and advance directive laws once again can create dilemmas for physicians, leading to situations of maternal-fetal conflict. The dilemma may involve a physician who disagrees with the pregnant woman's right to have her advance directive followed and include situations of continuing or discontinuing treatment. Also, a physician who discusses the pregnant woman's advance directive with her and agrees with her plan of treatment may find it impossible to carry out her wishes because of restrictions and limitations under state law.

In reality, few physicians discuss making an advance directive with their pregnant patients as most of these patients are young and healthy. Little data is available as to whether routinely having a pregnant woman make an advance directive reduces maternal-fetal conflicts or influences state laws.

2.6 Criminal Law and the Fetus

There are other areas of law where fetuses are given status and protection. One of these involves state and federal criminal law. According to Alan Wassertrom, this is partly because without a statute, common law holds that there is no crime if a fetus dies before birth. Only if a child dies after being born as a result of an act committed while the child was in-utero does a crime occur.[197] However, the laws vary as to the severity of the punishment, how embryos, fetuses, and unborn children are defined, and at what stage the laws apply.

2.6a Federal Law

The Unborn Victims of Violence Act became law in April 2004.[198] The law applies to federal and military crimes, making it a separate offense if the crime causes death or bodily injury to the fetus, with punishment the same as that for death or injury to the pregnant woman.[199] Essentially, the fetus has the same status as the pregnant woman in these cases. The law does not apply to the pregnant woman, physicians, or if she has consented to an abortion.[200] "Unborn child" in this act is defined as "child in-utero" who is "a member of the species homo sapiens at any stage of development who is carried in the womb."[201]

Objections to this law include the fact that it creates parity between harming the unborn and the pregnant woman which establishes symmetry between the rights of the two.[202] The law can result in courts needing to balance the rights of the fetus and the pregnant woman when conflict occurs, giving the fetus a status above that of an already born individual.[203]

2.6b State Law

Similarly, most states have some laws that deal with the intended or unintended death of a fetus by a party other than the pregnant woman or a physician. There are twenty five states whose homicide laws include fetuses at any stage of development, as the federal law does.[204] In most states, this includes some or all of the crimes of assault, battery, voluntary and involuntary manslaughter, criminally negligent, vehicular, or reckless homicide, and various murder charges.[205] Ten other state laws are similar to those described above, but put an age limit on the fetus. Two states set this limit at a specific week – Arkansas at twelve weeks or more and California at seven or eight weeks or greater.[206] The remaining eight state laws apply at viability of the fetus or quickening which is when fetal movement is felt by the mother.[207] The use of viability or quickening as a time frame for fetal homicide laws can be traced back to the born alive rule from sixteenth century English common law.[208] The point when life could be clinically observed was used to define live birth according to this law.[209] If one's act against a pregnant woman resulted in a miscarriage before quickening, it was not punishable and after quickening it was a misdemeanor.[210] New York has some conflicts in its legislation as one homicide law applies to a fetus after twenty four weeks while another law defines homicide as applying to a person born and alive.[211]

Of the homicide laws that include fetuses as victims, the states vary as to how they define an embryo, fetus, or unborn child. Kansas defines an "unborn child" at any stage as a "person" and "human being" solely for the purposes of this law.[212] Oklahoma defines "unborn child" as "unborn offspring of human beings."[213] Mississippi defines "human beings" as including "unborn child" and further defines "unborn child" as a member of the species homo sapien.[214] Seven states, Alaska, Georgia, Kentucky, Nebraska, Ohio, Pennsylvania, and South Carolina, define "unborn child" as a "member of the species homo sapien."[215] Arizona gives a fetus the same status as a minor under twelve years of age.[216] The remaining states do not specifically define the terms embryo, unborn child, or fetus.[217]

2.6c Summary

Similar to the varying degrees of status and protection seen with the court rulings and advance directive laws, states vary in how the fetus is viewed and its status when it is harmed or killed by someone besides the pregnant woman or a physician or other health care provider. Once again, the states are not consistent when it comes to the law and the fetus.

2.7 Federal Research Laws

One other final area where the pregnant woman's rights and government interests in protecting life conflict is federal laws concerning consent for pregnant women participating in research. The Code of Federal Regulations Part 46 Protection of Human Subjects includes pregnant women in the category of vulnerable populations.[218] They are "likely to be vulnerable to coercion or undue influence."[219] For this reason, the federal

government has enacted additional protections and requirements. These are found in Subpart B - Additional Protections for Pregnant Women, Human Fetuses and Neonates Involved in Research. The subpart describes the specific conditions under which pregnant women and fetuses can participate in research. These include having preclinical studies to assess potential risk to fetuses and pregnant women; the intervention or procedure has the potential to directly benefit the fetus and/or pregnant women and is the only cause of risk to the fetus, or if there is no potential benefit to the fetus, there can be no more than minimal risk to the fetus and the research must be done to obtain biomedical knowledge that cannot be gotten any other way; and the research involves the least possible risk in order to meet the research's objectives.[220]

Informed consent for pregnant women is also part of the law. The consent of the pregnant woman, obtained as specified in Subpart A for consent for anyone participating in research, is sufficient only:

> If the research holds out the prospect of direct benefit to the pregnant woman, the prospect of a direct benefit both to the pregnant woman and the fetus, or no prospect of benefit for the woman nor the fetus when the risk to the fetus is not greater than minimal and the purpose of the research is the development of important biomedical knowledge that cannot be obtained by any other means.[221]

However, section 46.204(e) states:

> If the research holds out the prospect of direct benefit solely to the fetus, then the consent of the pregnant woman and the father is obtained in accord with the informed consent provisions of subpart A of this part, except that the father's consent need not be obtained if he is unable to consent because of his unavailability, incompetence, or temporary incapacity or the pregnancy resulted from rape or incest.[222]

Section 46.204(d), which requires just the pregnant woman's consent, is in keeping with common law and constitutional rights of due process, liberty, privacy, and bodily

integrity. Section 46.204(e), however, is not since it also requires paternal consent, even though the father is not the research subject. One reason given in support of paternal consent is respecting and acknowledging the father's rights to protect the welfare of his unborn child.[223] Though this is a federal law, the provision is similar to the state interest to protect innocent third parties interests, in this case the father. The government has weighed the interests of involved parties and allowed other interests to take precedence over the rights of the pregnant woman, despite the fact that fetal research cannot be done without the direct participation of the pregnant woman and may require the pregnant woman, in some cases, to undergo an invasive procedure for the benefit of her fetus. The pregnant woman alone does not get to decide what is best for her and the fetus in this situation. Once again, inconsistencies exist in the law. The inconsistencies can lead to situations of maternal-fetal conflict.

2.8 Conclusion

As shown above, state and federal laws and court rulings are inconsistent as to the status and rights given to the fetus despite the fact that the fetus is not considered a person with the rights afforded to a person under the Fourteenth Amendment of the United States Constitution as determined in Roe v. Wade.[224] However, the United States Supreme Court also ruled that states have an interest in protecting the potential life of the fetus as it grows, along with the health and life of the pregnant woman. These interests must be balanced with the pregnant woman's liberty rights.[225]

The state and federal courts interpreted Roe v. Wade to both support and deny the pregnant woman's liberty rights. The Georgia courts in the Jefferson case denied the pregnant woman's right to refuse treatment, instead favoring the state interests in

protecting potential life based on Roe.[226] The federal court in the Pemberton case used a similar interpretation of Roe, ruling against the pregnant woman's liberty rights.[227] In both these cases, the courts cited the fetus' right to life as greater than the intrusion or imposition placed on the pregnant woman by undergoing the cesarean section. In the Doe case, however, the Illinois Appellate Court interpreted Roe as supporting the pregnant woman's right to refuse treatment.[228] The court believed the intrusion on the pregnant woman was greater than the fetus' right to life.

Unfortunately, no clear tendencies, consensus, or guidelines emerge from these rulings. Perhaps the only consensus is expressed by the federal court in Pemberton which said that states do not have to follow other states' rulings concerning compelled cesarean sections.[229] The various courts did not base their decisions on previous state rulings but on their own interpretations of Roe and other laws. The Pemberton case did set forth a possible guideline when denying the pregnant woman's liberty rights due to the fact that the case involved an exceptional circumstance. No physician would agree to perform a vaginal delivery based on Mrs. Pemberton's medical history.[230]

The courts and state legislatures are not consistent in their balancing and interpretation of the above competing interests of the pregnant woman and fetus. The liberty rights of the pregnant woman to make decisions accepting or rejecting a medical treatment or procedure, whether competent or incompetent through the use of her advance directive, have been acknowledged by state and federal courts. But in only two of the four cases of forced cesarean section discussed in this chapter, the courts ruled that the pregnant woman's liberty right took precedence. In one of these cases, In Re A.C., the entire appeals court based their final decision on the substituted judgment standard and

not on the balancing of the above two interests. The court in this case actually stated that the balancing approach was wrong.[231] In the other two cases, the courts determined that the state interest in protecting the potential life of the fetus took precedence over the pregnant woman's liberty rights. Similar to this, thirty three states and the District of Columbia restrict enacting a woman's advance directive in some manner if she is pregnant. There are other instances of this state interest taking precedence over the pregnant woman's rights. These includes recent laws such as the 2005 federal laws on pregnant women and fetuses as research subjects, the 2004 Unborn Victims of Violence Act, and state fetal homicide laws.

Unfortunately, there is no way to predict how a court will rule on a case of forced cesarean section, even from a lower court to a higher court within the same state or jurisdiction. The Jefferson rulings, the initial rulings in In Re A.C., and the Pemberton rulings all protected the potential life of the fetus. Doe's rulings and the final ruling of In Re A.C. upheld the pregnant woman's liberty rights. These decisions, though initially evolving over time from protecting the fetus to protecting the rights of the pregnant woman, did not continue in that direction and reverted back to protecting the fetus' life. Lower court rulings are issued in time limited, somewhat emergent situations. There is not always extensive time for research and deliberation of the case as with appeals that are heard after the fact. But even this type of situation does not result in consistent, predictable rulings, as seen with In Re A.C. and Pemberton. Courts appear to look at each case individually, balancing the pregnant woman's liberty rights and the state interest in protecting the potential life of the fetus as they see fit. There are no clear cut guidelines that all courts follow. Balancing in favor of the pregnant woman's liberty rights is not

guaranteed. Likewise, favoring a fetus at term is not guaranteed. Balancing these two interests is not even seen as the appropriate approach by all the courts.

There is also no consistency between court rulings and advance directive laws concerning pregnancy in individual states. State advance directive laws cannot be used as a predictor of how a state court will rule in a case of maternal-fetal conflict. Neither the state laws nor court rulings reference the other. There is no way to know if the judicial or legislative bodies consider the other's rulings or laws in an attempt at consistency.

Also, states are inconsistent in advance directive laws. No uniform standards exist for advance directives and pregnant women. Physicians and pregnant women cannot assume these laws will be the same or even close to the same from state to state, especially since the laws can range from no restrictions to invalidating the advance directive during pregnancy and everything in-between.

Physicians, pregnant women, administrators, and others involved in situations of maternal-fetal conflict, when looking to the legal system to resolve the conflict, cannot confidently predict how the court will rule, whether initially or on appeal. Previous cases are not guaranteed to be followed and state laws on advance directives are not a guide for the courts. Uncertainty and inconsistency are involved when turning to the legal system to resolve situations of maternal-fetal conflict, including forced cesarean sections. The outcome the physicians, administrators, and others involved are seeking may not be the way the court rules.

Unfortunately, these inconsistencies will not be resolved by examining philosophical ethical views of maternal-fetal conflict in the next chapter. Even though the fetus is not considered a person according to some philosophical theories or able to act

autonomously, similar inconsistencies are seen. Conflicts exist between respecting the autonomy of the pregnant woman to make decisions concerning her and her fetus' medical care and treatment versus acting for the benefit of the fetus, the principle of beneficence, and a pregnant woman's duty to her fetus, deontological theory. Examining the views of professional medical organizations versus the actual views of physicians reveals the same conflict. Professional medical organizations support the pregnant woman's legal rights and respect for her autonomy. However, some physicians favor beneficence towards the fetus and protecting the fetus' potential life, especially at term. The number of physicians supporting this view has decreased over time.

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[1] United States Supreme Court, "Roe V. Wade,". 22/Jan 1973, 21/11/2007 <http://tourolaw.edu/Patch/Roe/>.
[2] United States Supreme Court, "Roe V. Wade."
[3] United States Supreme Court, "Roe V. Wade."
[4] United States Supreme Court, "Roe V. Wade."
[5] United States Supreme Court, "Roe V. Wade."
[6] United States Supreme Court, "Roe V. Wade."
[7] United States Supreme Court, "Roe V. Wade."
[8] United States Supreme Court, "Roe V. Wade."
[9] United States Supreme Court, "Roe V. Wade."
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Chapter 3

Philosophical Ethical Views of Maternal-Fetal Conflict

3.1 Introduction

In addition to legal views, maternal-fetal conflict has been examined from secular philosophical viewpoints. The predominant philosophical theories concerning maternal-fetal conflict are principlism and deontology. However, these philosophical views do not help resolve the inconsistencies seen in chapter two. The chapter will begin with an examination of the philosophical moral theory of principlism and the pregnant woman's moral obligations to the fetus based on this theory. The role of respect for autonomy will be considered in the first section, as it is a dominant view in the philosophical literature addressing this subject. Two other components of principlism, beneficence and nonmaleficence, are discussed, along with how the principles may be weighed and balanced in a situation of maternal-fetal conflict. After that, deontological theory is examined. The chapter looks at some different deontological theories and how these theories view the pregnant woman's duty to her fetus. These duties place limitations on respecting the pregnant woman's autonomy and give priority to beneficence and nonmaleficence. However, the extent of the limitations vary depending on what

individual philosophers believe is the extent of the pregnant woman's duty. The chapter concludes by examining Kant's moral theory, the status of the fetus based on Kant's theory, and the resulting duties of the pregnant woman toward her fetus. Inconsistencies are seen between the above different philosophical ethical theories and the resulting moral obligations for the pregnant woman when faced with a situation of maternal-fetal conflict.

3.2 Principlism

Prinicplism is also called the four-principle approach to biomedical ethics.[1] The four principles of biomedical ethics, as defined by Beauchamp and Childress, are:

> (1) respect for autonomy (a norm of respecting and supporting autonomous decisions), (2) nonmaleficence (a norm of avoiding the causation of harm), (3) beneficence (a group of norms pertaining to relieving, lessening, or preventing harm and providing benefits and balancing benefits against risks and costs), and (4) justice (a group of norms for fairly distributing benefits, risks, and costs).[2]

According to Beauchamp and Childress, these principles are derived "from considered judgments in the common morality and professional traditions in health care"[3] and serve as guidelines or a framework for medical ethics. The choice of these principles is justified by the fact that they are acceptable to our culture and can be used to consistently deal with ethical questions.[4]

None of these four principles are absolute. They are prima facie principles that must be fulfilled unless there is a stronger competing obligation.[5] W. D. Ross stated that:

> when I am in a situation, as perhaps I always am, in which more than one of these prima facie duties is incumbent on me, what I have to do is to study the situation as fully as I can until I form the considered opinion (it is never more) that in the circumstances one of them is more incumbent than any other; then I am bound to think that to do this prima facie duty is my duty sans phrase in the situation.[6]

Prima facie principles in and of themselves are abstract and lack sufficient content to address moral problems. Beauchamp and Childress write that the principles require specification and balancing when they conflict to determine which one becomes the actual moral obligation.[7] Ross states that our judgments in an actual situation do not have the certainty that general principles of duty have.[8] Ross had no specific way of determining which conflicting duty is stronger and becomes the actual duty. James Fieser believes Ross used intuition as a guide, but thought this could be prone to error.[9] According to Ross, one's opinions are interpretations of sense – experience and these can actually be misinterpretations. Ross also stated in ethics there is no direct way to access facts about what is right or good except to think about them.[10]

John Rawls similarly wrote that intuitionist theories consist of first principles that can conflict and they give no method to determine which principle takes priority.[11] He does say that intuitionists describe how competing principles are balanced but that no expressible ethical conception underlies the weights given to the different principles.[12] Rawls states that "intuitionism denies that there exists any useful and explicit solution to the priority problem."[13] But intuition does allow one to determine the important criteria used to weigh the competing principles upon which hopefully all will agree.[14]

Unfortunately, all do not agree on the important criteria used when weighing and balancing prima facie principles. As discussed later, different philosophers give greater weight to one of the four principles than another and all do not agree as to which principle is the stronger duty in a situation of maternal-fetal conflict. Intuition differs among individuals. Since there are no specific guidelines to follow when determining which principle is stronger, as Ross says, an individual's decision is no more than a

considered opinion that is a duty for that individual. The lack of specific guidelines will not help in resolving situations of maternal-fetal conflict.

3.3 Respect for Autonomy

Even though none of the four principles of bioethics are absolute, Michio Miyasaka believes respect for autonomy appears to be the moral principle most widely accepted.[15] Beauchamp and Childress, however, deny that respect for autonomy should be placed above the other three principles.[16] Respect for the pregnant woman's autonomy means respecting her decisions concerning medical care for herself and her fetus. Limits to autonomy do exist, but disagreement occurs as to the extent of these limits.

3.3a Definition

Autonomy is a Greek word meaning self-rule or self-governance.[17] Autonomy in moral philosophy is based in an individual human's ability for self-determination.[18] Beauchamp and Childress describe personal autonomy as being:

> at a minimum, self-rule that is free from both controlling interference by others and from certain limitations such as an inadequate understanding that prevents meaningful choice. The autonomous individual acts freely in accordance with a self-chosen plan…A person of diminished autonomy, by contrast, is in some respect controlled by others or incapable of deliberating or acting on the basis of his or her desires and plans.[19]

There are two conditions believed to be essential for autonomy according to Beauchamp and Childress. These are liberty, defined as independence from controlling influences, and agency, defined as capacity for intentional action.[20] An autonomous person possesses the mental capacities necessary for understanding, reasoning, and independent decision-making.[21] Autonomous acts are done intentionally by an individual, are understood by the individual, and are free of any controlling influences that determine

the action such as constraint or coercion.[22] People who are capable of acting autonomously do not always do so for various reasons.

The idea of individual self-determination or self-rule leads to the principle of respect for autonomy. Respect for an autonomous person means recognizing the person's right to have his or her own beliefs and views, to make choices, and to act based on these beliefs and values, even if one disagrees with the person's beliefs, values, or decisions that result from them.[23] Included is an individual's right to make an autonomous decision to refuse a medical treatment or procedure, even when the physician or other health care professionals do not agree with the decision. Respect for autonomy also means others should not interfere with the decisions an autonomous individual has made. Respect for autonomy includes helping others develop the capacity to choose autonomously and removing barriers to autonomy.[24]

David McCurdy agrees that respecting an individual's autonomy is more than not interfering with that individual's decisions.[25] He views respect for autonomy as "an openness to and appreciation of the values, ideas, and history that lie behind patient choices," and refers to this as the individual's story.[26] McCurdy believes:

> an ethic of respect for stories is an ethic of empathy. To respect the person in the story is to try to see life from inside his or her framework.[27]

Respecting another's story may help one understand the reasons for an individual's decisions, even if one disagrees with the decision.

Similarly, McCullough and Chervenak point out that moral autonomy is distinct from legal autonomy by accenting:

> the moral particularities of each individual. That is, moral autonomy acknowledges that each of us is, in some important sense, a unique configuration and history of particular values and beliefs that form the

> basis for our determination of our own subjective and deliberative interests.[28]

These values and beliefs are formed by cultural resources such as religion, family, and personal experience which may have a common basis, leading to an individual, unique perspective.[29] The individual perspective is the same as what McCurdy calls the patient's story. Since each individual's story is different, it is not unusual for different individuals to make different decisions in the same situation. Respecting individuals' autonomy can lead to different perspectives concerning a situation of maternal-fetal conflict.

Respecting another's autonomy also means allowing the individual to make decisions free from coercion.[30] In this context, coercion refers to one individual's intentionally controlling another through the use of a severe and credible threat of force or harm.[31] The exception to this is if an individual's action is going to cause harm to another individual. Other exceptions include endangering public health or the inability to pay for a scarce resource. An individual's autonomy may also be limited by respect for another's autonomy. For example, a patient cannot violate a physician's autonomy and integrity by asking the physician to comply with an act that the physician morally opposes.[32]

3.3b Respect for Autonomy and Pregnancy

According to Bruce L. Miller "a competent person is one who has the capacity for autonomy, and a competent decision is one that is autonomously made."[33] Not all individuals are capable of autonomous actions or making autonomous choices. In some cases this may be temporary, such as someone under the influence of medication or anesthesia, or it may be permanent. Examples of individuals who cannot act

autonomously are the immature, exploited, coerced, or incapacitated.[34] Included in this category of non-autonomous agents are fetuses. No fetuses meet any of the criteria of the capacity for autonomy. Fetuses are not capable of independent action or choosing. Fetuses do not have values and beliefs or their own perspective of their interests.[35] Therefore, one cannot respect the autonomy of the fetus.

In contrast to the fetus, most pregnant women do possess the capacity to make autonomous decisions. In other areas of life besides medical decisions concerning her pregnancy, women use their values and beliefs to make complex autonomous decisions without their ability to do so being questioned.[36] Physicians need to respect and honor decisions made by pregnant women concerning their medical care and treatment based on the principle of respect for autonomy, the same as they would with non-pregnant patients, even when they disagree with the patients. The American College of Obstetricians and Gynecologists states respecting decisions made by autonomous, informed patients is a "fundamental ethical obligation of health care professionals."[37] Respecting autonomous decisions of patients also applies to pregnant women whether they are making informed autonomous decisions for themselves and/or their fetuses. Since fetuses cannot make their own decisions concerning their health care and treatment, pregnant women must do so for them. Being pregnant in and of itself does not diminish a woman's ability to make autonomous decisions concerning health care and treatment for her and/or her fetus. Based on the principle of respect for autonomy, a pregnant woman can choose whether or not to have a recommended cesarean section and her decision must be respected by the physician, even if it results in harm to her fetus.

But, as discussed earlier, respect for autonomy is not an absolute principle. There are limits to an individual's autonomy, pregnant or not. Choosing to live as part of an organized society limits individual autonomy through laws that govern individual's lives and bodies, such as the use of illegal drugs and the selling of one's organs.[38] Autonomy is also limited by one's voluntary relationships with spouses, parents, and children and the duties that are a result of these relationships.[39] The pregnant woman's relationship with her fetus and the duties that result from this relationship may limit her autonomy. These duties should not only limit but inform and influence the pregnant woman's autonomous decisions for her and her fetus. Ignoring these limitations to autonomy, Thomasma et al point out:

> generates a cult of moral privatism, atomism, and individualism that is insensitive to the fact that humans are members of a moral community. When autonomy is absolutized, each person is a moral atom who asserts his or her rights independently and even against the claims of the social entity to which he/she belongs.[40]

But as discussed later in the chapter, disagreement exists as to the extent of limitations on respecting another's autonomy, especially that of pregnant women.

3.4 Balances to Autonomy

Since respect for autonomy is a prima facie principle, it must be balanced with the principles of justice, beneficence, and nonmaleficence by the pregnant woman and her physician when faced with a situation of maternal-fetal conflict. However, no clear method of balancing these principles exists that will help resolve the conflict.

3.4a Justice

Justice is described by Beauchamp and Childress "as fair, equitable, and appropriate treatment in light of what is due or owed to persons."[41] They go on to state:

> a holder of a valid claim based in justice has a right, and therefore is due something. An injustice involves a wrongful act or omission that denies people resources or protections to which they have a right.[42]

Aristotle's minimal formal requirement of justice is "equals must be treated equally and unequals must be treated unequally."[43]

Appeals have been made to this minimal formal requirement of justice concerning maternal-fetal conflict. The requirement of justice supports respecting the pregnant woman's autonomy when making decisions concerning her and/or her fetus' medical care and treatment. The American College of Obstetricians and Gynecologists Committee on Ethics believes that:

> the principle of justice,… requires that individuals (in this case, both pregnant and nonpregnant patients) be treated fairly. Those who argue against court-ordered intervention invoke the principle of justice, arguing that generally, one individual cannot be compelled to undergo medical treatment, particularly surgery, to benefit another.[44]

ACOG goes on to say:

> that a woman's right to refuse invasive medical treatment that would benefit another should not be diminished because she is pregnant. Justice requires that pregnant and nonpregnant individuals should be afforded similar rights.[45]

The application of the principle of justice does not necessarily take the fetus into account. As to whether or not philosophically the principle of justice also applies to the fetus depends on whether or not one considers the fetus a person with equal status to the pregnant woman. However, since the fetus is incapable of autonomous actions and any medical care or treatment that a fetus needs also involves the pregnant woman, the

question becomes what weight does the pregnant woman give to the principle of justice when balancing it with the other three principles and how does the pregnant woman interpret the principle. Differences will exist on these issues among individuals when faced with a situation of maternal-fetal conflict.

3.4b Nonmaleficence

Respect for autonomy is not an absolute principle that is automatically a stronger obligation than the other three principles. Weighing and balancing respect for autonomy with other goods results in a more valid judgment.[46] Balancing the principle of respect for autonomy are the principles of nonmaleficence and beneficence.

Beauchamp and Childress describe nonmaleficence as imposing "an obligation not to inflict harm on others."[47] The principle's origins are uncertain and it is abstract in nature, but it has been common to codes of medical ethics as the "maxim primum non nocere: 'Above all, do no harm."[48] This includes the Hippocratic Oath, Florence Nightingale's Pledge for Nurses, and present day codes for physicians and nurses. Beauchamp and Childress define harm, as used in this principle, in the "nonnormative sense of thwarting, defeating, or setting back some party's interests."[49] The principle also includes an obligation to not impose a risk of harm on another, whether or not the harm to another is intended or one is aware of imposing or inflicting the harm.[50] In sum, Beauchamp and Childress state "rules of nonmaleficence (1) are negative prohibitions of action, (2) must be followed impartially, and (3) provide moral reasons for legal prohibitions of certain forms of conduct."[51] Nonmaleficence is the equivalent of W.D. Ross' "not injuring others" which Ross similarly believes is distinct from beneficence and is a more stringent duty.[52]

Concerning maternal-fetal conflict, nonmaleficence requires the pregnant woman and her physician not to harm the fetus. The principle also requires the physician not to harm the pregnant woman. Inconsistency exists when applying this principle once again as the physician and pregnant woman may have different views of what harm to the pregnant woman and/or the fetus consists of. The physician may believe any risk to the fetus' health and/or life during delivery is a harm, whereas the pregnant woman may believe having surgery is a harm.

3.4c Beneficence

While nonmaleficence requires one not to do something harmful and is negative, the principle of beneficence is positive. The term beneficence, according to Beauchamp and Childress, "connotes acts of mercy, kindness, and charity" and "includes all forms of action intended to benefit other persons."[53] They define the principle of beneficence as "a moral obligation to act for the benefit of others."[54] W.D. Ross similarly defined the duty of beneficence as "there are other beings in the world whose condition we can make better in respect of virtue, or of intelligence, or pleasure."[55]

According to Beauchamp and Childress, that William Frankena has four elements to the principle of beneficence:

(1) One ought not to inflict evil or harm
(2) One ought to prevent evil or harm
(3) One ought to remove evil or harm
(4) One ought to do or promote good[56]

For Frankena, beneficence, which he also refers to as utility, is one of two basic principles of morality. He defines beneficence as maximizing the total amount of good

over evil in the world.[57] The other basic principle for Frankena is justice. Both are prima facie principles.[58] Frankena believes the basic obligation is:

> we ought to do good and to prevent or avoid doing harm. If we did not have this more basic obligation, we could have no duty to try and realize the greatest balance of good over evil.[59]

Beauchamp and Childress point out "generally, obligations of nonmaleficence are more stringent than obligations of beneficence, and, in some cases, nonmaleficence overrides beneficence, even if the best utilitarian outcome would be obtained by acting beneficently."[60] But beneficence, with its positive demands, requires more of individuals than nonmaleficence.[61] According to Beauchamp and Childress "rules of beneficence (1) present positive requirements of action, (2) need not always be followed impartially, and (3) generally do not provide reasons for legal punishment when agents fail to abide by them."[62] Not causing harm to the fetus and/or the pregnant woman is a more stringent obligation than doing good for the fetus and/or the pregnant woman and gives one criterion for determining which principle is the strongest.

3.4d Obligations of Beneficence

The same as with respect for autonomy, the principles of nonmaleficence and beneficence are not absolute. One of the problems of beneficence is the extent of its obligations on individuals. Larry Churchill states there are two ways beneficence obligations are limited. The first is "duties to oneself, including one's own well-being and self-respect" and the second is "our psychological capacity for identification of and sympathy with those who could use our help."[63]

Beneficence broadly defined demands morally extreme generosity and severe sacrifice. Therefore, many see this as an ideal and virtuous behavior.[64] But beneficence

can be obligatory towards those with whom one has a special relationship, such as friends and family, and is termed specific beneficence. General beneficence refers to everyone. Beauchamp and Childress believe it is unrealistic to expect the same obligations with general beneficence as specific beneficence.[65] Some obligations of specific beneficence are based in reciprocity. We help another since we have been helped in the past or will be helped in the future by another. These obligations can also be contractually or role based, requiring specific commitments and promises to another.[66] Physician-patient relationships and pregnant woman-fetus relationships fall under the category of specific beneficence and require the physician and pregnant woman to act for, respectively, the patient's and the fetus' good and to do more than not cause harm to either. The obligation of specific beneficence may limit one's autonomy.

Beauchamp and Childress give five conditions for general beneficence in which person X has a specific obligation of beneficence toward person Y:

> 1. Y is at risk of significant loss of or damage to life or health or some other major interest.
> 2. X's action is needed (singly or in concert with others) to prevent this loss or damage.
> 3. X's action (singly or in concert with others) has a high probability of preventing it.
> 4. X's action would not present very significant risks, costs, or burdens to X.
> 5. The benefit that Y can be expected to gain outweighs any harms, costs, or burdens that X is likely to incur.[67]

All five conditions must be met, with number four being the most important condition of the five, for general beneficence to be obligatory.[68] But these conditions are not needed in the pregnant-woman and physician-patient relationship for specific beneficence to exist. Specific beneficence exists due to role based commitments. If one does apply the above five criteria to the pregnant woman who is advised to have a cesarean section for the

benefit of her fetus, all five criteria are met. The pregnant woman will have an obligation of specific beneficence to her fetus regardless of role based commitments.

Based on the above, the pregnant woman has an obligation of specific beneficence, based both on Beauchamp and Childress' five criteria and on her role as a future parent to her fetus, to do good for her fetus. Doing good for the fetus means undergoing the cesarean section to prevent death or severe injury to her fetus. Not causing harm to the fetus also results in the same decision for the pregnant woman. These two principles in this situation do not conflict and specific beneficence does not require more from the pregnant woman than nonmaleficence does. The particular situation essentially fits all four of Frankena's elements of beneficence.

3.4e Conflicts of Respect for Autonomy, Beneficence, and Nonmaleficence

There is no clear view, in general, as to whether respect for autonomy, beneficence, or nonmaleficence is a priority, or whether acting beneficently means always respecting another's autonomy.[69] Obligations of specific beneficence make beneficence a priority, in general, over respect for autonomy and nonmaleficence for the pregnant woman. Similarly, McCullough and Chervenak's opinion is that for the physician, beneficence focuses on the patient, looking for the greatest benefit of good over harm. They believe beneficence supersedes nonmaleficence.[70] The physician's beneficence-based obligation towards the fetus is a result of the physician knowing from a medical viewpoint what is in the fetus' best interests.[71] But the fetus' best interests may not take into account the pregnant woman's best interests. As will be discussed in chapter

four, physicians differ as to whether they view the pregnant woman and her fetus as one patient or two separate patients.

Conflict can occur as to whether respecting the pregnant woman's autonomy or the beneficence obligations of the physician to the pregnant woman and/or fetus are a priority when these two views differ. Conflict can also occur between respect for autonomy and nonmaleficence. Likewise, there can be conflict over whether a pregnant woman's autonomous decisions concerning her and her fetus' care are most important or whether her parental role obligations of specific beneficence to her fetus take precedence when the two are not the same. The physician's and pregnant woman's weighing and balancing of these principles may not result in the same outcome.

Similar to the legal concepts of the pregnant woman's liberty rights and the state interest in protecting the life of the fetus, the bioethical principles of respect for autonomy of the pregnant woman and beneficence and nonmaleficence toward the fetus and/or the pregnant woman do not always give consistent answers to the pregnant woman's moral obligation to her fetus when faced with a situation of maternal-fetal conflict. Based on respect for autonomy, a pregnant woman can refuse a cesarean section that benefits her fetus or both her and her fetus. Beneficence, however, obligates her to act in the best interests of the fetus and do good for the fetus when medically required, especially when the harm to her is minimal and outweighed by both the benefit to her fetus and the harm to the fetus she is preventing. This is based on her obligation of specific beneficence to her fetus. Nonmaleficence likewise obligates the pregnant woman not to inflict harm on her fetus. No clear guidelines exist on how the pregnant woman should weigh and balance the above principles. Different women will arrive at different

answers. Nonmaleficence and beneficence will not always result in the same outcome as in this specific situation. Beneficence and nonmaleficence obligate the pregnant woman to have the cesarean section to do good for her fetus and prevent harm to it in this situation.

3.5 Duty to the Fetus

Another philosophical theory that has been used to try to resolve situations of maternal-fetal conflict is deontology, looking at the pregnant woman's duty to her fetus. These duties are usually believed to be a result of the pregnant woman's role and relationship with her fetus. Many philosophers agree the pregnant woman has duties to her fetus, but disagreement exists among philosophers as to the extent of these duties.

3.5a Consequentialism and Deontology

Consequential theories determine the rightness or wrongness of actions based on the amount of good or bad consequences they produce.[72] According to David Kelly:

> Acts are right or wrong only according to their effects. An act is a right act if its effects are positive, good ones; it is a wrong act if its effects are negative, bad, harmful ones.[73]

Utilitarianism, one form of consequentialism, uses the principle of utility to determine right and wrong actions. Actions that produce the greatest amount of good or positive value over bad or disvalue are right.[74] However, disagreement occurs among individuals over what is to be valued and whether one looks to acts or rules to determine right and wrong.[75] Some examples of things to be valued include happiness, health, knowledge, and success.[76]

Consequentialism can be applied to situations of maternal-fetal conflict. Reasonably foreseeable consequences or outcomes of actions can be weighed to determine what the pregnant woman and/or physician should do when faced with a situation of maternal-fetal conflict. But disagreement exists over what is to be valued or is a right act. For example, respecting the autonomy of the pregnant woman may produce the most value or the pregnant woman and/or physician acting for the good of the fetus or not harming the fetus may produce the most value. Others may value different outcomes. The pregnant woman and her physician may not agree on what is to be valued. Different conclusions will be reached depending on what an individual believes produces the most value or good, once again creating inconsistencies when trying to resolve maternal-fetal conflict.

Deontology is the philosophical theory of acting out of duty or obligation. According to James Fieser moral duties involve what I owe others as opposed to moral rights which are what others owe me. Focusing on moral duties as opposed to moral rights will make us better persons.[77] Deontological theories, in general, look to rules and duties, what we are obliged to do, as opposed to consequentialism which looks at consequences or effects of actions to determine right or wrong.[78] In general, when maternal-fetal conflict occurs, the question posed is what is the pregnant woman's moral obligation or duty to her fetus and/or what is the physician's moral obligation or duty to the pregnant woman and fetus; or in Fieser's terms, what does the pregnant woman owe her fetus and what does the physician owe the pregnant woman and fetus. The question arises out of the unique physical relationship of the pregnant woman and the fetus and the fact that treatment of one affects the other.[79]

3.5b Beneficence and Nonmaleficence in Duty Theory

The first philosopher to develop a traditional duty theory was Samuel von Pufendorf in the 1600's. Pufendorf saw humans as having duties to God, oneself, and others.[80] Pufendorf classified duties toward others as absolute and hypothetical. Absolute duties apply to all humans. Hypothetical duties are determined by a specific condition and apply to only some humans.[81] The first absolute duty for Pufendorf is not to harm others. Not harming others is a duty of omission and is the most essential duty to maintaining social life with others.[82] Harming another for Pufendorf includes direct or indirect harm or destruction to the individual or their property.

Pufendorf also includes as another duty towards others is to be useful to others. Being useful especially includes freely giving others those things which are beneficial and harmless to the other while not burdening the giver. However, according to Pufendorf:

> it is a higher degree of humanity to give something to another freely from extraordinary benevolence, if it involves expense or labor to give it and if it relieves his needs or is exceptionally useful to him… The amount of these benefits and their distribution depend on the condition of the giver and the recipient.[83]

Pufendorf's duty theory promotes nonmaleficence and beneficence and gives a clear guide for one's behavior, unlike principlism and consequentialism which have no absolute duties. Based on Pufendorf's theory, the pregnant woman has an absolute obligation to not cause physical harm to her fetus. She should also be useful to the fetus and act for its benefit, but this is not an absolute duty. Whether this involves extraordinary beneficence depends on whether any burden is involved in doing good for the fetus. Pufendorf's theory puts beneficence and nonmaleficence toward the fetus over

respecting the pregnant woman's autonomy. Pufendorf's limitation to the pregnant woman's duty to act for the good of the fetus is that doing so does not burden the pregnant woman. But her duty not to harm her fetus is absolute. Likewise, the physician has an absolute duty to not harm others and should do good for both the pregnant woman and the fetus if it is not burdensome.

Pufendorf also discusses duties of parents and children. Parents have a duty to care for their children, with children giving tacit consent.[84] He states that one can assume that if an infant could reason at birth and know that care of his or her parents was necessary for survival, the infant would agree to the parents' care.[85] One could make the same statement about a fetus.

When applying Pufendorf's duty theory to a situation of maternal-fetal conflict, the first duty of all involved is not to cause harm to another. Refusing the cesarean section most likely will cause harm to the fetus. Having the cesarean section is not putting the pregnant woman at increased risk or burden so the physician would not be causing harm to the pregnant woman.

3.5c Moral Role Obligations to the Fetus

Other philosophers speak of obligations to another that arise as a result of one's role or profession, although these obligations can vary in their interpretation by different individuals.[86] Moral role obligations can also result from one's voluntary relationships. Examples of this are duties physicians have to patients and parents have to children. Parents have obligations to care for their children since children are considered vulnerable.[87]

Some philosophers likewise believe a pregnant woman has obligations to her fetus. Philosophers differ as to the reasons they give for parental obligations to fetuses. Janna Merrick believes that parental duties to a child include caring for the fetus and involves restrictions on the pregnant woman's autonomy.[88] Merrick bases the pregnant woman's obligations to her fetus on the fact that the fetus becomes the born child. Robert Blank thinks it is unreasonable to conclude a pregnant woman has no obligations to her fetus. He believes "the more severe the harmful effects on the fetus and the higher the risk of that effect occurring, the higher should be the standard of care."[89]

Ian Kennedy also believes that a pregnant woman has a duty to her fetus which limits her autonomy. He takes the position that a fetus has rights. He states these rights are weak since the fetus's fate is dependent on the pregnant woman. The fetus' rights become stronger as the fetus grows and reaches viability.[90] The primary duty of the pregnant woman, for Kennedy, is not to interfere with these fetal rights, especially the fetus' right to not be exposed intentionally to harm and to be born free from avoidable harm. To do this, he proposes a calculus consisting of eight elements to determine the extent of the pregnant woman's duty.[91] The calculus weighs the claims of the pregnant woman and the fetus and concludes if the claim of the fetus is strong and that of the pregnant woman is weaker, she has a duty to undergo treatment or surgery for her fetus' benefit.[92]

Bonnie Steinbock's opinion is that when a woman decides not to abort and to carry a fetus to term, the fetus is no longer a "potential child but a child-who-will-be-born."[93] The reason is the same as Merrick gives. She writes that this changes the pregnant woman's moral obligations to her fetus since once the fetus is born it will have

interests, including being healthy and free of pain. However, she does not refer to this as a fetus' right as Kennedy does. A woman's behavior during her pregnancy can affect the future child's interests.[94] According to Steinbock:

> insofar as these risks are unnecessary or unreasonable, taking them is morally wrong, a violation of parental duty. So there are things that pregnant women ought to do, or refrain from doing, not only for her health, but for the sake of the baby.[95]

However, she believes it is not the fact that pregnant woman have moral obligations to their fetuses that is controversial, but rather what constitutes these obligations and the limits of the obligations.[96]

Ruth Macklin agrees with Steinbock and Kennedy that there is probably universal agreement on the propositions that it is better for infants to be born healthy and free from preventable disabilities and diseases. Macklin states that "once a decision is made to carry a pregnancy to term, pregnant women have a moral obligation to act in ways likely to result in the birth of a sound, healthy infant."[97] She also sees this as an obligation owed to the future child not the fetus like Merrick and Steinbock.[98] But this duty is limited by the pregnant woman's physical or psychological ability to comply with it. But uncertainty exists for Macklin as to what "constitutes a 'reasonable ability to comply."[99] Macklin's uncertainty is the same as Steinbock's uncertainty as to the limits of the pregnant woman's duty. If extenuating circumstances, like religious beliefs, do not exist, she believes the pregnant woman should fulfill her duty to the fetus as a moral obligation is presumed to exist.[100]

However, the same argument of the pregnant woman having a duty to her fetus since it becomes the born child has been interpreted differently. George Annas points out that no parent has ever been compelled to have surgery for the benefit of a child, for

example, to donate an organ to the child.[101] Annas believes it would be ironic for a pregnant woman to have to undergo a procedure that a parent would not have to.[102] Annas believes the pregnant woman's duty to her fetus should not be greater than that to her child.

Laura Purdy writes that she disagrees with Annas and believes the pregnant woman has some duties to her fetus since it is dependent on her in a unique way unlike any other and that what happens during the pregnancy will affect the fetus after when it is a person. But she also states the pregnant woman does not owe the fetus more than she owes her child.[103] Included is undergoing surgery for the sake of the fetus.[104] Despite her statements otherwise, Purdy essentially agrees with Annas as to the limitations of the pregnant woman's duties to her fetus. Annas and Purdy define a definite limit to the pregnant woman's duty to her fetus unlike Merrick, Blank, Kennedy, Steinbock, and Macklin.

3.5d. Summary

As shown above, many philosophers believe a pregnant woman has duties to her fetus based on the unique relationship between the pregnant woman and her fetus in which the fetus is totally dependent on the pregnant woman for its growth, development, and survival. The reasons for this include the fact that the fetus is a future child whose best interests include being born free from disability, diseases, and harm. Some philosophers believe a fetus has rights that are stronger the closer the fetus gets to birth. Others believe the duty is stronger as the risk of harm occurring to the fetus increases.

Duties of the pregnant woman to the fetus include not causing harm to the fetus and doing good for the fetus. Pufendorf believes humans not causing harm to another is

an absolute duty. He discussed parental duties to children but does not specifically mention the fetus. When specifically discussing the pregnant woman's duties to her fetus, other philosophers do not consider not causing harm to the fetus an absolute duty. Rather, the debate and disagreement is over what is the extent of the duty not to cause harm or to do good for the fetus.

Once again, philosophical theories are not consistent. Moral duties and obligations that some philosophers believe a pregnant woman has to her fetus will guide the pregnant woman's decisions concerning medical care and treatment for her and her fetus during pregnancy. These duties generally give priority first to nonmaleficence, not harming the fetus, and beneficence, acting for the good of the fetus. But not all philosophers agree as to the extent of the duties of pregnant woman toward her child-to-be and the limitations of these duties.

When a pregnant woman is advised to have a cesarean section to prevent death or serious injury to her fetus, her duty to not cause harm to her fetus obligates her to undergo the cesarean section. Doing good for the fetus likewise obligates her to have the cesarean section, allowing the fetus to be born free of disability and disease. However, this is not part of the pregnant woman's duty for Annas and Purdy as they believe a pregnant woman should not be obligated to undergo surgery for the benefit of the fetus.

3.6 Kantian Ethics and the Fetus

Immanuel Kant's ethical theory is another example of a deontological or duty based theory.[105] In this part of the chapter, I examine Kant's theory as to whether or not the fetus is considered a person for Kant and whether the pregnant woman has moral obligations to her fetus.

3.6a Definition of Person

Kant's moral theory is based on reason. Kant writes "the basis of obligation must not be sought in nature of man or in the circumstances in the world in which he is placed, but a priori simply in the conception of pure reason."[106] Pure reason for Kant is practical reason and does not derive from the empirical or the senses. He states:

> reason is imparted to us as a practical faculty, that is as one which is to have influence on the will,…its true destination must be to produce a will, not merely good as a means to something else, but good in itself, for which reason was absolutely necessary.[107]

Kant also writes:

> rational beings alone have the faculty of acting according to the conception of laws – that is, according to principles, that is, have a will. Since the deduction of actions from principles requires reason, the will is nothing but practical reason.[108]

Kant refers to rational beings as persons:

> because their very nature points them out as ends in themselves, that is, as something which must not be used merely as a means, and so far therefore restricts freedom of action (and is an object of respect).[109]

Persons are objective ends. They are not means but ends in themselves. According to Fieser, Kant believes persons are the only ones capable of following reason and able to freely make decisions.[110] Reason sets them apart from other creatures, such as animals.[111] Kant places animals in the category of things, according to Hasnas, as they are not self-conscious beings.[112]

The above concept of a person being an end in him or herself leads to Kant's ideas of dignity and autonomy. Only those who are capable of being ends in themselves have dignity or intrinsic worth. According to Kant:

> morality is the condition under which alone a rational being can be an end in himself, since by this alone it is possible that he should be a legislating

> member in the kingdom of ends. Thus morality, and humanity as capable of it, is that which alone has dignity.[113]

Kant also states "autonomy then is the basis of the dignity of human and of every rational nature."[114] Autonomy consists of moral reasoning and willing and is internal to persons for Kant, not external.

Kant's views on autonomy and dignity have been interpreted by various authors. Michio Miyasaka believes "for Kant, autonomy and dignity were founded consistently on the same ground- it is the capacity of lawgiving itself (autonomy in the strict sense) which must have dignity."[115] Autonomy is internal for Kant. According to Eric Krakauer, "we give ourselves the law rather than taking it from outside of ourselves; we are autonomous."[116] Kant's internal autonomy differs from the autonomy discussed in principlism which is external. Miyasaka states that with principlism persons are judged autonomous based on external observations in view of others where as for Kant a person is autonomous based on internal "considerations in view of herself."[117] Nicole Gerrand believes that for Kant, if something has a price, an equivalent thing can be substituted for it. However, if something has dignity, no equivalent exists as it is exalted above any price.[118] If something has dignity, it cannot be exchanged for anything or anyone else; it is irreplaceable.[119]

One's ability for rational willing, developed or undeveloped, does not vary among persons for Kant nor is it a matter of degree according to R. George Wright.[120] Wright states "it is therefore, among persons, a matter of commonality rather than distinction."[121] However, he thinks Kant distinguishes between good conduct, which is proper respect for humanity, and bad conduct, which expresses contempt or disrespect for humanity.[122]

3.6b Status of Fetus

Based on the above, various authors have interpreted Kant as believing not all human beings are persons. Wright states "for Kant, mature members of our species who are not severely mentally incapacitated count among rational humanity."[123] Gillon writes that any human who is not capable of rational willing agency is not a person by Kant's definition.[124] Those who are not persons includes, for example, infants, children, severely mentally challenged adults, and adults who are unconscious, demented, or in a persistent or permanent vegetative state. Based on Kant's definition of person, there are human beings who will never be able to be called persons. Likewise, a fetus does not meet Kant's definition of a person. The fetus is definitely not capable of rational willing agency.[125] A fetus may qualify as a potential person, although Kant never uses this term, but even this is not certain as this capability in a future individual is not known until the individual is born and grows and develops as to whether or not his or her ability to reason develops as normally expected.

Miyasaka states that for Kant, those who are not persons also do not possess dignity and autonomy, as they are not capable of being ends in themselves or capable of lawgiving.[126] Included in this group are fetuses. But of course, there is no definition of autonomy that includes the fetus, as the fetus is completely dependent on the pregnant woman prior to birth for its existence. A fetus is not capable of acting, except for movement, or existing on its own while in the uterus. Even the fetus' movement is limited to its confines within the pregnant woman's uterus. The fetus does not meet the definition of either internal or external autonomy.

A fetus does not possess dignity per Kant. The fetus has no intrinsic value in and of itself since it is not a person. Kant, in The Metaphysics of Morals, writes that on the level of nature, man and animals both have ordinary value:

> Although a human being has, in his understanding, something more than they and can set himself ends, even this gives him only an extrinsic value for his usefulness; that is to say, it gives one man a higher value than another, that is, a price as of a commodity in exchange with those animals as things, though he still has a lower value than the universal medium of exchange, money, the value of which can therefore be called preeminent.[127]

One hopes that Kant includes the fetus among humans and animals that possess ordinary value, although one cannot be sure about this based on Kant's views. Whether Kant views the fetus as a commodity or if the fetus has ordinary value for usefulness as a potential person since the fetus cannot do anything until after it is born and develops is uncertain.

Kant does say in the Critique of Practical Reason that respect applies only to persons, not things.[128] Respect, for Kant, is "not mere admiration"[129] but "always rests on the consciousness of a duty which an example shows us, and that respect, therefore, can never have any but a moral ground."[130] For Kant, respect should be given equally to all persons and not based on one's preferences according to Wright.[131] However, the fetus is not deserving of respect, as the fetus is not a person by Kant's definition. R. M. Hare believes one can have inclinations toward the fetus and feel affection for the fetus.[132] But the idea of respect for life or for the fetus as a living being or potential being is not appropriate based on Kant's definition of respect since the fetus is not capable of rational moral behavior that is deserving of our respect. The pregnant woman can have inclinations or desires of love or other feelings toward her fetus that are not based on the

fetus being a person capable of following the law. But she and others cannot have respect for the fetus by Kant's definition.

Kant also bases personhood on one's actions. He writes "a person is a subject whose actions can be imputed to him. Moral personality is therefore nothing other than the freedom of a rational being under moral laws."[133] Kant describes a thing as "that to which nothing can be imputed."[134] A thing is not capable of forming maxims, only persons are.

Kant divides the Metaphysics of Morals into the doctrine of right and the doctrine of virtue. Kant defines the doctrine of right as "the sum of those laws for which an external lawgiving is possible."[135] Rights concern actions and are, per Kant, "the sum of the conditions under which the choice of one can be united with the choice of another in accordance with a universal law of freedom."[136] For Kant, this freedom concerns external acts and leads to the universal law of right that states: "so act externally that the free use of your choice can coexist with the freedom of everyone in accordance with a universal law."[137] Kant believes that his free choice to act, known as liberty, is the only natural right that man has occurring in a state of nature.[138]

Based on the above discussion, once again, a fetus cannot be considered a person for Kant, along with many other human beings as discussed previously, due to the fact that a fetus cannot have actions imputed to itself. Kant writes "imputation in the moral sense is the judgment by which someone is regarded as the author of an action, which is then called a deed and stands under law."[139] A fetus is incapable of any independent, external actions. A fetus also does not possess liberty, as a fetus is unable to make free choices that do not interfere with the free choice of others. A fetus is unable to make any

type of choice, free or not. The fetus is totally dependent on the pregnant woman for survival while it is in the uterus. Therefore, a fetus is a thing for Kant, something incapable of imputing actions.

Krakauer points out that Kant believes "there are those who are simply incapable of purpose or mental composure."[140] Individuals who are ruled by affect and passion instead of reason are immoral and unfree, which Kant sees as a mental or psychic problem.[141] Included here are children, who Kant believes are immature due to their age and women, who are ruled by passion.[142] Based on this analysis, it is reasonable to suggest that fetuses might be included in this category.

3.6c Parental Obligations to Children

Property occurs within a state for Kant under the principle of liberty and presupposes that a social contract exists.[143] Property, for Kant, includes ideal or intelligible possession – I can use it and no one else can without my consent. He writes:

> the way to have something external as one's own in a state of nature is physical possession which has in its favor the rightful presumption that it will be made into rightful possession through being united with the will of all in a public lawgiving, and in anticipation of this holds comparatively as rightful possession.[144]

Property, for Kant, is an agreement between all the persons in a state. According to Kant:

> possession is nothing other than a relation of a person to persons, all of whom are bound, with regard to the use of the thing, by the will of the first person, insofar as his will conforms with the axiom of outer freedom, with the postulate of his capacity to use external objects of choice, and with the lawgiving of the will of all thought as united a priori.[145]

Kant defines three types of things that one can possess as property – a physical thing external to me, another's choice to perform a specific act or performance, and another's status in relation to me. The last one includes a man's wife and children.[146]

Kant states concerning "on rights of persons akin to rights of things this right is that of possession of an external object as a thing and use of it as a person."[147] Here Kant defines physical possession as "the condition of being able to manage something as a thing, even if this must, in another respect, be treated at the same time as a person."[148] The parental right or the married couple acquiring children is included here. Kant believes:

> just as there arose from one's duty to oneself, that is, to the humanity on one's own person, a right of both sexes to acquire each other as persons in the manner of things by marriage, so there follows from procreation in this community a duty to preserve and care for its offspring; that is children, as persons, have by their procreation an original innate (not acquired) right to the care of their parents until they are able to look after themselves, and they have this right directly by law (lege), that is, without any special act being required to establish this right.[149]

Kant here refers to children as persons, which seems to contradict his previous definitions of persons since all children are not capable of rational acting. He may mean that he is only referring to children who have developed to the point where they are capable of reason. He thinks parents cannot destroy their child as they would a product that they made and that they are not the property of the parents since they are endowed with freedom.[150] This would also refer to children capable of rational moral action. But they, Kant believes, are "not just a right against a person, since a child still belongs to his parents as what is theirs… It is, instead, a right to a person akin to a right to a thing."[151] Parents do have an obligation to raise their children. According to Kant:

> from a practical point of view it is quite correct and even necessary idea to regard the act of procreation as one by which we have brought a person into the world without his consent and on our own initiative, for which deed the parents can incur an obligation to make the child content with his condition as far as they can.[152]

Exactly what status Kant gives to children here is hard to determine. But he is specific about parents having a duty to care for and raise their children.

In the Doctrine of Right, Kant discusses justice and punishment and states there are two crimes that are "deserving of death, with regard to which it still remains doubtful whether legislation is also authorized to impose the death penalty."[153] One of these crimes is a mother's murder of an illegitimate child to hide the disgrace she feels at having a child born outside of marriage in an attempt to preserve her honor.[154]

Kant does not specifically discuss the fetus when referring to children, although that stage is necessary for a married couple to acquire children. One can infer that there is a duty to the fetus, similar to that of parents to children, to preserve and care for fetuses, as they are potential children and future persons. Only if they are cared for when they are fetuses can they be born and develop into persons with freedom. In this sense the fetus would not just be the property of the parents or just a thing, as animals are, but instead potentially falls under Kant's "right to a person akin to a right to a thing."[155] If fetuses have a status similar to children, then they likewise cannot be destroyed by the parents.

Kant also discusses active and passive citizens of the state. Active citizens are independent persons who he states should have the right to vote and help make laws.[156] Passive citizens can be persons, but they are not independent. They include anyone who is dependent on another for their existence, such as apprentices, servants, women, and minors.[157] Fetuses, likewise, fall into this category as dependents. But they are not persons. They are not capable of moral reasoning and acting with freedom. They are part of the mother, literally inside of her. She is considered a passive citizen. But whether the

fetus has any status as a passive citizen for Kant is uncertain since they are not persons and are not part of society before their birth.

3.6d Summary

In summary, a fetus does not meet Kant's definition of a person, as the fetus does not possess rational willing agency and is incapable of having actions imputed to him or her. A fetus may have ordinary value for Kant and may be more than a thing for Kant since it is a future person, but this is not clear from his writings. The fetus may qualify, similar to children, as a "right to a person as akin to a right to a thing."[158]

3.7 Kantian Duties Toward Fetuses

A fetus does not have the status of a person based on Kant's writings. But, as discussed previously, some philosophers believe that pregnant women do have moral obligations or duties to their fetuses. In this section, I will examine whether a pregnant woman has duties to her fetus based on Kant's moral theory and how these duties apply to a situation of maternal-fetal conflict.

3.7a Indirect Duties

Kant writes, concerning duties in general:

> as far as reason alone can judge, a human being has duties only to human beings (himself and others), since his duty to any subject is moral constraint by the subject's will. Hence, the constraining subject must, first, be a person and this person must, second be given as an object of experience.[159]

Based on this, for Kant, a pregnant woman has no duties to her fetus as it is not a person. But, Kant does believe that human beings have indirect duties to animals that qualify as things.[160] The reason for these duties is humans' duty to humans, not humans' duty to

things. Kant believes cruelty to animals will lead to cruelty to humans. Cruelty to animals weakens and destroys valuable traits and corrupts humans' moral abilities. According to Bert Heinrichs, this is ethically problematic.[161] One can similarly infer, based on these same reasons, that a pregnant woman has an indirect duty to her fetus as cruelty to fetuses may likewise lead to cruelty to humans.

Duty, for Kant, is an action that is done out of respect for the moral law and is not a result of inclination or desire, but of reason. Duty is not derived from experience but rather is conceived beforehand and implies obligation. The problem with duty is one never knows if one is acting from pure duty, or from other empirical motives or inclinations.[162] The pregnant woman can have inclinations of love and other feelings toward her fetus. A pregnant woman's emotions and feelings toward the fetus, both positive and negative, may possibly overtake reason and duty in her decision-making process concerning her pregnancy as it is hard to imagine a pregnant woman acting only out of pure moral duty to her fetus.

3.7b Duties Based on the Categorical Imperative

Kant's first formulation of his categorical imperative states "act only on that maxim whereby thou canst at the same time will that it should become a universal law" or its variation "act as if the maxim of thy action were to become by thy will a universal law of nature."[163] According to this, the pregnant woman must will that her behavior toward her fetus can be willed as a universal law, acceptable for all to follow if in the same situation. The pregnant woman has two options in this example of maternal-fetal conflict. One is to have the cesarean section to save her fetus. The other is to refuse the cesarean section and let her fetus die or suffer harm. The first formulation of the

categorical imperative requires that her action or maxim must be able to be willed as a universal law. If she has the surgery and the fetus lives, this can be willed universally since her life is not endangered and it saves the life of her fetus. However, if she does not have the surgery and the fetus dies or suffers harm that cannot be willed universally. One cannot universally will that all pregnant women can refuse surgery or cesarean sections if needed and let their fetuses die or suffer harm.

The first reason for this can be based in Kant's example on suicide in the Fundamental Principles of the Metaphysics of Morals. Here Kant writes:

> Now we see at once that a system of nature of which it should be a law to destroy life by means of the very feeling whose special nature it is to impel to the improvement of life would contradict itself, and therefore could not exist as a system of nature; hence that maxim cannot possibly exist as a universal law of nature, and consequently would be wholly inconsistent with the supreme principle of duty.[164]

Similarly, letting fetuses die cannot be willed as a universal law as it destroys future life.

In the article "A Kantian Approach to Abortion" by R.M. Hare, a similar argument based on the first formulation of the categorical imperative is used. Hare believes that moral judgment must be the same in situations that are the same.[165] In the case of abortion, this leads to the judgment that pregnancies ought not to be terminated because, using himself as an example, he finds his life valuable and if his mother had an abortion, he would not have existed.[166] Therefore, he is happy he was born. He writes:

> The reason why most of us think that all things being equal pregnancies should not be terminated, is that we think that on the whole they are likely to result in people being born who will in the course of their lives be glad to have been born.[167]

Hare thinks this reasoning leads to a general principle that we not kill fetuses.[168] The same argument can also be applied to this example of maternal-fetal conflict.

Kant's second formulation of his categorical imperative states: "so act as to treat humanity, whether in thine own person or in that of any other, in every case as an end withal, never as a means only."[169] If one again looks at Kant's example of suicide, killing oneself is using oneself as a means to escape one's pain.[170] But since man is not a thing, he cannot be used as a means. Kant concludes "I cannot, therefore, dispose in any way of a man in my own person so as to mutilate him, to damage him, or kill him."[171]

In this dissertation's analysis, the cesarean section is not construed to be a case of mutilating the pregnant woman. Kant points out in this application of the second formulation of the categorical imperative "it belongs to ethics proper to define this principle more precisely, so as to avoid all misunderstanding, for example, as to the amputation of the limbs in order to preserve myself."[172] Kant allows removal of a body part to save one's life. Kant likewise articulates in the Metaphysics of Morals that it is okay to remove a dead body part if needed to save one's life.[173] The fetus and placenta are not essential body parts of the pregnant woman and do not endanger the pregnant woman. One can view the fetus as an extension of the pregnant woman, as a part of the pregnant woman since the fetus is physically attached to her and dependent on her for its survival until birth. Therefore, surgery is permissible as the placenta and in-utero environment are diseased and threatening the fetus' life. Removing the fetus and the placenta does not result in mutilation to either the pregnant woman or the fetus.

Michio Miyasaka, in the article on organ transplantation "Resourcifying human bodies – Kant and bioethics", takes Kant's views in the Metaphysics of Morals on removing diseased organs and points out:

> He distinguished a part from an organ of the human body, and accepted that a part can be separated from a body as far as it is willed by the person

> - to whom the part belonged – within universal moral laws. Willing to sell the part can violate moral laws, but willing to donate it to save another person's life can probably accord with them.[174]

Morelli similarly writes that donating one's organ to another for Kant is an act of beneficence and not treating oneself as merely a means. However, selling one's organs is always treating oneself solely as a means.[175]

If removing a part of one's body and donating it to save another's life is permissible, surely it is permissible for the pregnant woman to will the removal the fetus to save the fetus' life. No organs essential to the pregnant woman's survival are being removed or damaged. Only a part of the pregnant woman is being removed. She is not profiting monetarily by saving the fetus. Therefore, it is permissible to remove the fetus and placenta, based on Kant's views of allowing surgery to remove body parts as needed to save another or oneself.

3.7c Duty of Beneficence

Mats Hansson interprets Kant's duties of respect and beneficence to include not only those who qualify as persons for Kant, but those who are not capable of autonomous actions such as minors and the mentally deprived.[176] Hansson believes that if an object has potential to be a grown human being, then persons have a duty of beneficence toward the object. According to Hansson, "our duty to protect and promote what is essential to a human being's physical, psychical and moral existence becomes stronger the closer we get to a stage of development where these characteristics are actual."[177] Based on this, for Hansson, a viable fetus and morally autonomous person are the same thing.[178] Therefore, the pregnant woman has a duty of beneficence to her fetus.

Kant views beneficence as something that must be willed as a universal law.[179] If beneficence is not willed as such by an individual, then the individual will not receive the help he or she may need at some point in his or her future.[180] If the pregnant woman does not act beneficently toward her fetus and undergo the surgery to save the fetus' life, she is willing that she be deprived of any assistance she may need in the future to save her life. Having the surgery does not endanger her life. Based on the first formulation of the categorical imperative, it is the pregnant woman's duty to act beneficently toward her fetus.

In applying the second formulation of the categorical imperative to the example of beneficence, Kant writes: "now humanity might indeed subsist although no one should contribute anything to the happiness of others."[181] The statement ignores the fact that a pregnant woman must contribute her body to the fetus for the fetus to survive and develop, leading to the happiness of the fetus' birth and life. Without women doing this, humanity will cease to exist. The pregnant woman is already acting beneficently toward the fetus by providing an environment for the fetus to grow and develop until the fetus is born. Kant goes on to state that it would be wrong to ignore the happiness of others for the ends of others should also be one's own ends.[182] The happiness and end for the fetus is to be born and live free of disability and disease. The end of the fetus, based on this, should be in accord with the end of the pregnant woman. By allowing the pregnancy to develop and grow within her uterus, the pregnant woman is already making the happiness and end of the fetus her own happiness and end. By having the surgery to prevent death or harm to the fetus, she continues to act in accord with the happiness and end of the

fetus. If she refuses the surgery, she ceases to act beneficently toward the fetus, no longer promoting the fetus' happiness and end.

In the Metaphysics of Morals Kant again talks about beneficence under duties of love. He defines beneficence here as "the maxim of making others' happiness one's end, and the duty to it consists in the subject's being constrained by his reason to adopt this maxim as a universal law."[183] Kant believes it is one's duty to promote the other's happiness as needed without expecting anything in return. The other is not to be obligated to the one who acts beneficently. Rather, all should help each other because they may one day need help.[184] This is actually a combination of what Kant said about beneficence with the first and second formulations of the categorical imperatives in The Fundamental Principles of the Metaphysics of Morals. Therefore, the previous arguments that the pregnant woman should have the cesarean section apply here. But the pregnant woman, in the future, cannot expect her child to be obligated to her because she had the cesarean section. The pregnant woman should not expect anything in return. The child's obligations to his or her mother in the future are those he or she has based in reason and the moral law.

Kant also writes in The Metaphysics of Morals: "I cannot do good to anyone in accordance with my concepts of happiness (except young children and the insane), thinking to benefit him by forcing a gift upon him; rather, I can benefit him only in accordance with his concepts of happiness."[185] Perhaps the fetus can be aligned with Kant's stance on young children and the insane, insofar as the fetus is not construed to be a person for Kant. But if the pregnant woman's concept of happiness is to not undergo the cesarean section, this would not be doing good to the fetus as the fetus would die or

suffer harm. The pregnant woman's duty is to act in accord with the happiness of the fetus, as discussed previously, for that will result in the fetus living hopefully free of disease or disability. The pregnant woman's end must still be in accord with the fetus' end. The pregnant woman is not acting out of beneficence if she imposes her end or her happiness on the fetus. She is also not acting in accord with either formulation of the categorical imperative.

3.7d Duties in the Doctrines of Virtue and Rights

Duties are either perfect – negative ones that ought not to be violated, or imperfect – positive ones that each should fulfill to the best of one's ability.[186] In the doctrine of virtue, which concerns incentives and maxims, as opposed to actions as in the doctrine of right, Kant gives two ends that are also duties. These "are one's own perfection and the happiness of others."[187]

Wright interprets the duty to promote other's happiness as an imperfect moral duty, with controversy existing as to the limits of this duty.[188] Wright concludes that:

> in fulfilling their duty, people should begin with what should count as a justifiable limitation on our moral duty to assist others. It is clear that good faith judgment and sensitivity to circumstances will be required. Beyond this, at least where no special relationship exists, as that of bodyguard and employer, Kant's formula suggests that 'we may refrain from helping only if such action would place our own rational action in jeopardy.'[189]

However, a special relationship exists between a pregnant woman and her fetus, creating a duty for the pregnant woman to promote the happiness of the fetus.

As discussed above, beneficence fulfills the duty of promoting the happiness of others as it involves making others' ends one's own.[190] Kant believes that if morality consisted only of right, then benevolence, "satisfaction in the happiness (well-being) of

others," would not exist.[191] The world then would not be a moral whole. Therefore, to have a moral whole, the pregnant woman has a duty to take satisfaction in the happiness of her fetus.

The other end that is also a duty in the doctrine of virtue is one's own perfection, meaning one's moral perfection.[192] Kant writes "the first, though not the principle duty of a human being to himself as an animal being is to preserve himself in his animal nature."[193] The opposite of this is for one to kill oneself. Kant also sees it as a violation of one's duties to others, such as family members and a violation of one's duty to one's person since the person is destroying morality in the world by killing oneself.[194] Suicide is also treating oneself as a means and not an end. The analogy to suicide cannot be used to preserve the fetus' life as the fetus is not yet a person capable of reason and therefore, the fetus is not a source of morality. One is not destroying morality in the world if the fetus is allowed to die. One can only say that the fetus is a potential future source of morality after it is born. Of course, this is dependent on it developing normally into a human being who fulfills Kant's definition of a person. Also, the fetus currently has no duties to other family members, but will in the future after it is born and develops. The pregnant woman has the current duty to the fetus. She has a duty to preserve the fetus in its animal nature as a potential or future person. .

Heinrichs interprets Kant's duty to promote one's own perfection as promoting one's moral and natural perfection.[195] Promoting one's moral perfection as the duty for the pregnant woman in this example of maternal-fetal conflict means that she undergoes the cesarean section. This is a result of her acting out of duty and following the

categorical imperative. If she acts otherwise, she will not be promoting her moral perfection.

In the article "What should we want to know about our future? A Kantian view on predictive genetic testing", Bert Heinrichs states "what Kant highlights in the Doctrine of Virtue is that we have responsibilities toward others that transcend (enforceable) claims based on mere prudent reciprocity."[196] He thinks this becomes evident when Kant applies his duties of virtue to his casuistical questions. However, he concludes it is a difficult task to apply these duties to concrete issues, especially where conflicts of interest occur.[197] In a situation of maternal-fetal conflict, the pregnant woman's moral responsibility, based on the doctrine of virtue, requires her to promote the fetus' happiness and construe the fetus' end with her own. This duty goes beyond a prudent argument of causing the least harm. The prudent argument in this case has the same outcome, as avoiding the death of the fetus is the least harm, but Kant requires that it be done from the virtue of following one's maxims, of fulfilling one's duties. This transcends simply asking: what is the prudent thing to do?

Morally, Kant's doctrine of virtue shows that the pregnant woman has a duty to save the life of the fetus. But there is also the pregnant woman's duty under the doctrine of right to consider. Parents are obligated to raise their children until they are emancipated.[198] Raising children includes feeding, caring for, and educating the child, along with bringing about the child's proper moral development.[199] The duty to care for one's children can be extrapolated back to say that the parents are also responsible for the care of the child prior to his or her birth and to give the fetus the best chance to be born free of disease and disability. The pregnant woman's duty here is to choose to act so as to

give the child the best chance at a normal birth and life, provided it does not interfere with the freedom of others.

Under the doctrine of right, the right of necessity only applies if the fetus itself or if having the Cesarean section endangers the pregnant woman's life. According to Kant, "this alleged right is supposed to be an authorization to take the life of another who is doing nothing to harm me, when I am in danger of losing my own life."[200] Kant sees this situation as unpunishable by a judicial court, but not inculpable.[201] Since in this example of maternal-fetal conflict the pregnant woman's life is not being threatened in any way by the fetus or the surgery, the right of necessity does not apply.

Associated with the doctrine of right is the authorization to use coercion. Kant defines coercion as "a hindrance or resistance to freedom."[202] One can look at just this statement and make the assumption that requiring the pregnant woman to have the Cesarean section is a hindrance to her freedom to act. Therefore, she is not morally obligated to have the surgery. But Kant also states "whatever is wrong is a hindrance to freedom in accordance with universal laws."[203] Given this, since the pregnant woman's use of her freedom to refuse the Cesarean section is a wrong act and not in accordance with universal law, as shown previously in this paper, it is actually a hindrance to freedom. Coercion is allowable in this case to force the pregnant woman to have the surgery from a Kantian point of view, which is acting with freedom in accordance with the universal law. Kant believes:

> if a certain use of freedom is itself a hindrance to freedom in accordance with universal laws (i.e., wrong), coercion that is opposed to this (as a hindering of a hindrance to freedom) is consistent with freedom in accordance with universal laws, that is, it is right.[204]

The state, in this case, can coerce the pregnant woman to have the Cesarean section to save the life of her fetus. However, this Kantian view is contrary to the current United States legal and moral position which usually does not allow for coercion of individuals to undergo a surgery or medical procedure, even if it is necessary to save the individual's life or another's life as discussed previously.

3.7e Summary

In summary, even though the fetus does not fit Kant's definition of a person, the pregnant woman does have duties toward the fetus. These duties are based on the categorical imperative, beneficence, Kant's prohibition of suicide, and his allowing the removal of diseased body parts. The pregnant woman's moral duty or obligation to her fetus, from a strictly Kantian viewpoint, is to have a cesarean section to prevent death or severe injury to her fetus when her life is not endangered.

3.8 Conclusion

As shown above, philosophical ethical theories do not give a consistent answer when applied to a situation of maternal-fetal conflict. A fetus is not capable of acting autonomously so the pregnant woman must make decisions for it. In the philosophical theory of principlism, respecting a pregnant woman's autonomy means respecting her decisions concerning medical care and treatment for her and her fetus, even if these decisions result in harm or death to her and/or her fetus. However, nonmaleficence requires her not to cause harm to her fetus. The pregnant woman also has a role obligation of specific beneficence to her fetus. None of these three principles are absolute and must be balanced and specified, but this process will not necessarily result in

consistent answers, as all will not give the same weight to the different principles. Likewise, some philosophers agree pregnant women have duties to their fetuses but may not always agree as to the extent of these obligations and duties. In deontological theories, duties of beneficence and nonmaleficence toward the fetus take priority and may limit the pregnant woman's autonomy. For Pufendorf, not causing harm to another is an absolute duty. Other philosophers will limit the extent of the pregnant woman's duties to her fetus based on her ability to carry them out or by not requiring more that a parent's duty to a child. In a Kantian deontological theory, the pregnant woman has duties to her fetus even though it does not meet Kant's definition of a person, based on the categorical imperative, beneficence, prohibition of suicide, and allowing the removal of diseased body parts.

Unfortunately, the legal and philosophical inconsistencies will not be resolved by examining professional views of maternal-fetal conflict. Inconsistencies exist between ethical opinions of major professional medical organizations and studies of individual physician's opinions. Inconsistencies also exist as to whether or not the fetus is viewed as an individual patient separate from the pregnant woman by physicians and others or if the fetus and pregnant woman is one patient.

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Chapter 4

Professional Views of Maternal-Fetal Conflict

4.1 Introduction

Professional views of maternal-fetal conflict do not resolve the inconsistencies seen in legal and philosophical ethical theories. No agreement about resolving maternal-fetal conflict exists. Neither does an agreed upon view of the role of cesarean section in obstetrical care exist. Chapter four will first look at the recommendations of professional medical organizations on maternal-fetal conflict. The organizations' official opinions and guidelines support the legal rights and autonomy of the pregnant woman. However, the views of individual physicians are not always consistent with the organizations' positions, often favoring beneficence and respect for fetal life.[1] The chapter will also examine inconsistencies in physicians' views of the fetus as a patient - whether the fetus and pregnant woman are one-patient, a maternal-fetal dyad, or whether the fetus is a separate patient from the pregnant woman, giving the physician two patients. Finally, the chapter will look at the shift in how obstetricians view cesarean section. Traditionally, the purposes of cesarean sections are to save the pregnant woman's or fetus' life, decrease risk of neurological injury to the fetus, and preserve the anatomy of the pregnant woman.[2]

Elective cesarean section without a medical indication, which was rarely done in the past, is now on the rise and accepted more and more as an optional routine method of delivery at the pregnant woman's request.

4.2 Professional Medical Organization Views

Professional medical organizations address maternal-fetal conflict in articles, guidelines, and opinion statements. In general, these documents uphold the pregnant woman's legal right to determine her and her fetus' medical care and treatment, along with supporting respect for autonomy from a philosophical view over beneficence or her duty to help the fetus. These policies and opinions are normative claims, based on research and moral theories.

4.2a Guidelines and Opinions

The American Medical Association (AMA), American College of Obstetricians and Gynecologists (ACOG), England's Royal College of Obstetricians and Gynaecologists (RCOG), the International Federation of Gynecology and Obstetrics (FIGO), and the Royal College of Physicians and Surgeons of Canada (RCPSC) all have published articles, guidelines, or opinions concerning maternal-fetal conflict or the pregnant woman's refusal of treatment. FIGO's document is "Ethical Guidelines Regarding Interventions for Fetal Well Being" developed in March 1998. The RCPSC article is entitled "Reflection on the Physician's Responsibility to Mother and Fetus" published in April 1993. RCOG's guideline is "Law and Ethics in Relation to Court-Authorized Obstetric Intervention", second edition, from September 2006. The AMA published a paper in November 1990 titled "Legal Interventions During Pregnancy: Court

Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women" and also has a policy "H-420.969 Legal Interventions During Pregnancy." ACOG published the committee opinion "Patient Choice in the Maternal-Fetal Relationship" in January 2004. The document was initially issued in 1987 and revised several times since then. A second committee opinion from ACOG entitled "Maternal Decision Making, Ethics, and the Law" was published in November 2005. The American Academy of Pediatrics (AAP) Committee on Bioethics statement "Fetal Therapy - Ethical Considerations" was retired and not replaced. The AAP does not have a document on maternal-fetal conflict or refusal of treatment by pregnant women.

The above documents are guidelines and recommendations for the members of these organizations on handling maternal-fetal conflict and pregnant women's refusal of treatment. As the RCPSC article declares "the Royal College's Biomedical Ethics Committee is a forum for reflection, education, and advice to the members on the ethical challenges presented to contemporary medicine."[3] ACOG similarly believes "the purpose of the second edition of Ethics in Obstetrics and Gynecology is to help obstetricians and gynecologists understand and apply the concepts of biomedical ethics to problems in clinical practice, research, and the provision of health care in the community."[4] One can infer from these statements that these documents are primarily educational without any binding force on the different organizations' members.

The documents all acknowledge the unique relationship between the pregnant woman and fetus, with the fetus being totally dependent on the pregnant woman. Treatment of the fetus can only occur through the pregnant woman.[5] The papers also discuss the shift to considering the fetus a patient that has occurred with the development

of technology. According to ACOG, this view of the fetus as a separate patient results in divergent interests of the pregnant woman and fetus.[6]

ACOG, RCOG, FIGO, and the AMA all discuss the two types of decisions the pregnant woman makes that affect the fetus. These are, ACOG writes, "1.) the pregnant woman may refuse a diagnostic procedure, medical therapy, or a surgical procedure intended to enhance or preserve fetal well-being; and 2.) the pregnant woman's behavior may be deleterious to the fetus."[7]

The above articles, guidelines, and opinions differ in length and focus. The emphasis differs concerning legal and ethical principles involved in the pregnant woman's decision making for her and her fetus and the physician's duty to the pregnant woman and her fetus. FIGO, ACOG, and RCPSC focus primarily on ethical aspects while RCOG and AMA emphasize legal aspects. Despite these different approaches, all reach a similar conclusion. The best course of action is communication and education of the pregnant woman, as opposed to coercion, in an attempt to resolve the conflict. The RCPSC also recommends enlisting the assistance of others when needed.[8] The organizations all acknowledge the limitations in the accuracy of medical evaluation and diagnosis. Also, education of pregnant women and access to treatment for substance abuse is recommended as it fosters cooperation and trust with physicians.[9]

4.2b American Medical Association

The American Medical Association's Board of Trustees, in response to cases such as In Re A.C. which sought to compel treatment of pregnant woman, issued a report in the Journal of the American Medical Association on November 29, 1990 addressing court-ordered medical treatment of pregnant women.[10] The document originated from the

AMA's Committee of Medicolegal Problems, not the ethics committee.[11] "Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women" points out that women who see their pregnancy to term have a moral duty to ensure the health of their fetuses.[12] However, this does not lead to a similar legal duty. The article discusses court cases concerning pregnant women refusing treatment and the fact that, in general, courts do not impose a legal duty for one individual to aid another.[13] The Board of Trustees characterizes the duty of the pregnant woman to her fetus as that of a parent to a child.[14] The Board cites the "Samaritan law" special relationship of parent and child, but states even this obligation is minimal and does not require the parent to endanger him or herself for the child.[15] The Board also examines a parent's moral and legal duty, enforced by the State, to ensure that her child receives needed medical care, within reason. According to the Board, a pregnant woman who refuses medical care is also refusing medical care for her fetus. But medical care and treatment for the fetus can involve invasive procedures to the pregnant woman, along with risks to her health and life that the AMA believes the pregnant woman should not be forced to undergo.[16]

Like some philosophers, the AMA believes ethically the physician's duty includes acting for both the pregnant woman's and fetus' interests.[17] However, this does not allow the physician to balance the interests of one against the other when the pregnant woman refuses treatment. Doing so undermines and deprives the pregnant woman of her right to informed consent.[18] The AMA also recommends that physicians should not seek court-ordered treatment of pregnant women. The recommendation is based on: the courts are not equipped to resolve conflicts, especially in an emergency; lack of consistency when

court-ordered treatment is sought; legal obligations would be created for physicians, requiring them to seek and enforce court-ordered treatment; and seeking court-ordered treatment would damage the physician-patient relationship.[19]

The AMA's analysis of the pregnant woman's duty to her fetus is primarily legal in nature. Specific ethical principles that underlie the pregnant woman's duty to her fetus are not discussed. The legal focus is probably a result of the document coming from the Committee of Medicolegal Problems as opposed to the ethics committee. The other four organizations' documents were developed by their ethics committees.

The AMA's policy on maternal-fetal conflict is entitled "H-420.969 Legal Interventions During Pregnancy." The policy consists of the six recommendations made at the end of the above article and upholds the pregnant woman's autonomy. The AMA believes physicians have a duty to provide a pregnant woman with the information she needs to make an informed decision concerning medical care and treatment for her and/or her fetus. However, physicians should not influence or force her decision. Specifically, point two of the policy states "the physician's duty is to provide appropriate information, such that the pregnant woman may make an informed and thoughtful decision, not to dictate the woman's decision."[20] The policy also recommends physicians "should not be liable for honoring a pregnant woman's refusal of medical treatment designed to benefit the fetus" and documenting the pregnant woman's refusal.[21] The pregnant woman should not face criminal or civil sanctions if her behavior harms her fetus. Rehabilitation and treatment should be provided to the pregnant substance abuser.[22]

The AMA policy is not absolute in respecting the pregnant woman's autonomy. The policy leaves open the ability to seek judicial intervention in exceptional circumstances.[23] The policy states:

> Judicial intervention is inappropriate when a woman has made an informed refusal of a medical treatment designed to benefit her fetus. If an exceptional circumstance could be found in which a medical treatment poses an insignificant or no health risk to the woman, entails a minimal invasion of her bodily integrity, and would clearly prevent substantial and irreversible harm to her fetus, it might be appropriate for a physician to seek judicial intervention. However, the fundamental principle against compelled medical procedures should control in all cases which do not present such exceptional circumstances.[24]

The policy gives no specific examples that might meet these requirements. Instead, the policy defers to the physician's judgment to interpret if a medical treatment meets these exceptional circumstances.

4.2c American College of Obstetricians and Gynecologists

The American College of Obstetricians and Gynecologists opinion concerning maternal-fetal conflict is similar to the AMA's. As John Paris observes:

> both the ACOG and AMA believe that, while a pregnant woman may have a moral responsibility to accept medical procedures that benefit the fetus, the physician should not compel her to do so. Both groups note that medical benefits cannot be 'guaranteed absolutely,' that court orders for fetal intervention are hastily made, that such management threatens or destroys the doctor-patient relationship, and that the 'criminalization' of noncompliance with medical recommendations is undesirable.[25]

ACOG writes in its "Code of Professional Ethics," concerning the physician-patient relationship, under Ethical Foundations:

> the welfare of the patient (beneficence) is central to all considerations in the patient-physician relationship. Included in this relationship is the obligation of physicians to respect the rights of patients, colleagues, and other health professionals. The respect for the right of individual patients

> to make their own choices about their health care (autonomy) is fundamental.[26]

ACOG currently has two Committee Opinions by the Committee on Ethics addressing maternal-fetal conflict. The first is "Patient Choice in the Maternal-Fetal Relationship." When faced with a situation of maternal-fetal conflict, the physician, after exhausting all attempts to persuade and explain, has three choices, according to ACOG: 1.) to respect the patient's autonomous decision regardless of the outcome; 2.) for the patient to transfer her care to another physician; or 3.) to request the court intervene, which is rare.[27] ACOG is the only organization to suggest transferring the patient to another physician who will honor her wishes when conflict occurs and there is time to arrange this. None of the other organizations even mention this option despite the fact that physicians may have religious or other ethical reasons for not complying with the pregnant woman's decision. Transferring care, when it does not endanger the pregnant woman or her fetus, provides an acceptable solution for all involved parties.

The three ethical principles to be considered in cases of maternal-fetal conflict, according to ACOG, are autonomy, beneficence, and justice. Nonmaleficence is not discussed. In most cases, respecting the pregnant woman's autonomy provides the best outcome for her and her fetus. However, when it does not and there is no time to transfer care to another physician, ACOG recommends that "the obstetrician must respect the patient's autonomy, continue to care for the pregnant woman, and not intervene against the patient's wishes regardless of the consequences."[28] Justice requires pregnant and non-pregnant patients to be treated similarly as the courts have not ordered a non-pregnant person to undergo a medical procedure for the benefit of another.[29] The principle is the

ethical equivalent of courts not imposing a legal duty on one person to aid another as the AMA points out.[30]

ACOG discusses the ethical concepts more in-depth than the other organizations except the RCPSC. ACOG also includes the alternative approaches of treating the pregnant woman and fetus as a unit and the need to understand the social, cultural, and economic context in which the pregnant woman's decisions are made.[31] These theories are not raised by the other organizations. The theories provide other perspectives from which common ground may exist to resolve conflict.

Similar to the AMA, ACOG believes seeking court intervention is rarely acceptable. ACOG gives four criteria to be met for seeking court intervention:

> 1.) there is high probability of serious harm to the fetus in respecting the patient's decision; 2.) there is high probability that the recommended treatment will prevent or substantially reduce harm to the fetus; 3.) there are no comparably effective, less-intrusive options to prevent harm to the fetus; and 4.) there is high probability that the recommended treatment also benefits the pregnant woman or that the risks to the pregnant woman are relatively small.[32]

These four criteria must be weighed against the harm done to the pregnant woman by not respecting her autonomy, the pregnant woman's loss of trust in the health care system, and other social costs.[33] According to ACOG, not even a court order justifies "the use of physical force against a resistant, competent woman."[34]

Like the AMA, ACOG gives no specific examples of cases to which the exceptions may apply. Individual physicians must make their own judgments. But both organizations' criteria leave much room for interpretation. Different physicians will have different ideas of what constitutes serious harm or risk of serious harm to the fetus, especially given the limitations of testing to assess fetal well-being and obstetricians'

malpractice fears if a less than perfect outcome occurs. Likewise, insignificant or small risks to the pregnant woman are also subject to interpretation. Physicians may judge the amount of risk different from a pregnant woman since the physician performs or recommends a treatment or procedure on a regular basis. Both organizations' criteria are subjective, not objective in nature.

These vague criteria for not respecting a pregnant woman's autonomy and seeking court intervention do not clarify or support ACOG's ethical or the AMA's legal position respecting the pregnant woman's autonomous decisions. Physicians, when faced with a situation of conflict, may view the criteria as justification for seeking court intervention. Individual physicians can interpret any specific situation as meeting the criteria. The lack of specificity of the criteria leaves much room for exceptions and relies on individual physician judgment which will be influenced by the physician's personal ethical beliefs and legal concerns. Physicians may be reluctant to not intervene without legal authorization. Physicians may also believe they are compelled to seek court intervention based on their perceived duties to the fetus as a patient. Neither organization mentions consulting an ethicist or ethics committee for assistance in determining when a particular situation meets these criteria.

ACOG's Committee Opinion Number 321 "Maternal Decision Making, Ethics, and the Law," upholds and expands upon the above committee opinion's conclusions. The opinion emphasizes respect for the autonomy of the pregnant woman, informed consent, and not seeking judicial intervention or punishing a pregnant woman if her decision results in an adverse fetal outcome.[35] The opinion also gives six reasons against coercive and punitive legal approaches. They are: these approaches fail to recognize the

competent adults' right to bodily integrity and informed consent; there are limitations to medical knowledge and predictions of outcomes; addiction and mental illnesses should not be treated as moral failings; discouragement of necessary prenatal care leads to increased infant mortality rates and harms physician-patient relationships; legal interventions target the poor and vulnerable; and seeking legal intervention could potentially criminalize many behaviors that can result in adverse pregnancy outcomes.[36] The reasons are similar to those given by the AMA.

4.2d RCPSC

The "Annals RCPSC" article "Reflection on the Physician's Responsibility to Mother and Fetus" by the Biomedical Ethics Committee of the Royal College of Physicians and Surgeons of Canada emphasizes that the RCPSC is responsible for educating its members.[37] The article looks at the pregnant woman's fiduciary role toward the fetus and the physician's duty to benefit and not harm the fetus, along with balancing beneficence toward the pregnant woman with her autonomy.[38]

From a legal perspective, the article states that rarely does a case of maternal-fetal conflict end up in the legal system, resulting in "needless pain, criticism, and some 'bad' court decisions." Therefore, the RCPSC believes courts are not the proper venue to resolve conflict.[39] If a pregnant woman is incompetent; a valid surrogate should make decisions.[40] ACOG and the AMA do not discuss incompetent patients. RCPSC's recommendations differ from the RCOG's appeal to legal guidelines and the courts for incompetent pregnant women as will be discussed later.

Most of the paper discusses ethical issues involved in maternal-fetal conflict and gives five specific cases with comments. The comments, however, point out issues and

questions raised by the different cases, but do not give any answers or guidelines for handling the cases. The other organizations documents do not include discussion of ethical issues about specific cases. The RCOG analyzes legal cases in depth. ACOG uses cases merely to illustrate examples of maternal-fetal conflict.

The article places an emphasis on ethics education of physicians and outlines ethical obligations of physicians. The college also emphasizes fidelity and beneficence in the physician-patient relationship, along with the four principles of bioethics.[41] The RCPSC recommends when caring for pregnant women, physicians should look to beneficence and nonmaleficence, making decisions in the best interests of the fetus.[42] The RCPSC believes the pregnant woman is a moral fiduciary of her fetus with an obligation to act in the best interest of the fetus. Beneficence is also a priority for the pregnant woman.[43]

Concerning the physician's ethical obligation to the pregnant woman, the college believes the physician should act beneficently, but should also respect the pregnant woman's autonomy. However, unlike other organizations, the RCPSC writes "when these ethical principles are in conflict, autonomy as an absolute principle to be abrogated only when it harms innocent parties is insufficient. Beneficence and autonomy must be balanced."[44] By contrast, the AMA believes balancing the fetus' and pregnant woman's interests is not appropriate.[45] ACOG gives priority to the pregnant woman's autonomy over beneficence.[46]

The RCPSC gives no specific suggestions or in-depth discussion on how to balance beneficence and autonomy. In a sense this is similar to the AMA's and ACOG's vague guidelines for exceptions to seeking court intervention. Much room is left for

interpretation by individual physicians based on the situation and the physician's moral values, beliefs, and legal concerns. The recommendation leaves open the possibility that physicians may reach the conclusion that the benefits of treatment to the fetus and/or the pregnant woman outweigh respecting the competent pregnant woman's autonomous decision and impose treatment against her wishes. Since the RCPSC discourages seeking court-orders, physicians may believe they have an ethical basis to impose treatment and not view this as coercion.

As the College points out, legislative responses to these issues are inadequate and guidelines are needed, along with review boards, to address reproductive issues. They believe an autonomy-based ethic is inadequate due to the uniqueness of the maternal-fetal relationship.[47] The RCPSC recommends to their fellows a multidisciplinary approach to maternal-fetal conflict though they do not specifically mention involving ethicists or ethics committees. In fact, none of the five organizations recommend ethics consults. The RCPSC stresses the importance of education for physicians, patients, and the public as opposed to the use of coercion.[48] The RCPSC is the only organization that calls for a formal route for addressing maternal-fetal conflict.

4.2e FIGO

The International Federation of Gynecology and Obstetrics' "Ethical Issues in Obstetrics and Gynecology" by the Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health includes a section titled "Ethical Guidelines Regarding Interventions for Fetal Well Being." FIGO makes nine points in these ethical guidelines. FIGO does not address the legal status of the fetus or court cases and how they may affect the ethical recommendations. Perhaps because it is an international

organization and status of the fetus and court rulings can vary from country to country. No mention is made either of not holding the physician responsible if the pregnant woman declines treatment as the AMA does.

According to the guidelines, if pregnant women have the necessary information and support, they will act to enhance their own well-being along with that of their fetuses.[49] When this does not happen, the pregnant woman should be counseled, fully informed, and provided support services, but FIGO states:

> no woman should be forced to undergo an unwished-for medical or surgical procedure in order to preserve the life or health of her fetus, as this would be a violation of her autonomy and fundamental human rights. Resort to the courts or to judicial intervention when a woman has made an informed refusal of medical or surgical treatment is inappropriate and usually counter-productive.[50]

FIGO also addresses decision-making when a pregnant woman is not competent. FIGO includes consulting surrogates, but emphasizes acting in the pregnant woman's best interests over those of the fetus.[51] FIGO is the only organization that recommends honoring the decisions of competent pregnant minors.[52]

FIGO gives no guidelines, as ACOG and AMA do, for exceptions to respecting the pregnant woman's autonomy or seeking legal action. FIGO also does not allow for balancing autonomy and beneficence as RCPSC does. FIGO does not discuss the legal and ethical principles they based their guidelines upon. There is no educational discussion or case examples. However, FIGO's other guidelines are similar. FIGO does cover all the major ethical issues in a short, concise manner in this document. There is no vagueness in this document or room for exceptions to FIGO's recommendations, unlike the other four organizations.

FIGO emphasizes information for the pregnant woman. More than that, they emphasize support for the pregnant woman in multiple points.[53] But the guidelines do not specify what type of support they mean. The guidelines may be more helpful to FIGO's members if the organization spelled out what support for pregnant woman was most beneficial to meet the goal of a healthy pregnancy for her and her fetus, resulting in a normal birth.

What is not known, and perhaps should be studied, is whether these short, concise guidelines or the longer documents of the AMA, ACOG, and RCOG, which include background, cases, principles, and explanations, are more accepted and valuable as educational tools for physicians and influencing physicians' views. Given the large time demands on physicians, a two or three page document may be read more than ones ranging up to eighteen pages in length. But physicians may also want explanations and justification for the guidelines and recommendations.

4.2f RCOG

England's Royal College of Obstetricians and Gynaecologists Ethics Committee Guideline No. 1 "Law and Ethics in Relation to Court-Authorized Obstetric Interventions" focuses on court-ordered cesarean sections and is:

> based on the fundamental premise in English law that the competent adult has the right to refuse treatment. Surgery without consent is, therefore, illegal.[54]

The RCOG believes it is not appropriate to seek court intervention if a pregnant woman refuses treatment. The decisions of a competent pregnant woman must be respected, even if they result in her and/or her fetus' death.[55] A pregnant woman's advance directive should be honored when it refuses treatment.[56]

The RCOG devotes the majority of the document to discussing legal views on maternal-fetal conflict despite being authored by the ethics committee. The guidelines include an extensive legal discussion of informed consent, refusal of treatment, and capacity to give consent, along with relevant legal cases and laws. Advance directives are also discussed in detail. The RCOG is the only organization that discusses advance directives.[57]

The second part of this document discusses ethical issues. The RCOG recommends:

> while doctors cannot force treatments on women, they can build trusting relationships, give advice, and use the power of communication and persuasion (but not coercion). So long as a doctor does everything within his or her ability and professional limits, and the mother fully understands them, if things go wrong, she alone shoulders the burdens of responsibility and guilt.[58]

The obstetrician, according to the RCOG, "must respect the woman's autonomy and her legal right to refuse any recommended course of action."[59] But there is no discussion of the ethical principles involved. RCOG states the pregnant woman's responsibility to her fetus increases throughout the pregnancy but gives no ethical justification for this statement. The document is lacking in ethical principles to be considered in maternal-fetal conflict.

The document details what to do when a pregnant woman refuses treatment, starting with an assessment of her decision-making capacity. The guidelines then give a list of what to document in the pregnant woman's record. If the pregnant woman is possibly considered not competent, the committee recommends evaluating her and gives legal steps for doing so.[60] The guidelines also include twelve steps for "Suggested

practice when declarations are sought from the Courts."[61] These are very specific and only apply when the pregnant woman's competence is questioned.

Even though the committee states several times that court-ordered treatment in the United Kingdom is extremely rare, this document devotes less than two pages to ethical aspects of maternal-fetal conflict. There is little explanation of why respect for the pregnant woman's autonomy is primary from an ethical perspective. The arguments presented are legal and the emphasis in the document is on legal cases and steps for seeking legal action. There seems to be a major disconnect between the recommendation for respecting the pregnant woman's autonomy and not coercing unwanted treatment and step-by-step directions for seeking legal intervention. The guidelines differ from all the other documents as none provide legal steps to seek court orders. The only reason for seeking a court order for treatment according to the RCOG is lack of decision-making competence.[62] By contrast, ACOG's and the AMA's vague exceptions to seeking court orders are up to the physician's discretion and do not mention the decision-making capacity of the pregnant woman. There is no clue in the document as to why the RCOG has this legal emphasis or approach. Coming from an ethics committee, it should at least be balanced in its discussion of ethical and legal principles, if not emphasizing ethical principles. One may infer it addresses obstetricians' primary concerns about being sued for malpractice or compelling necessary treatment for the fetus to protect the fetus from harm, especially if the obstetricians view the fetus as a separate patient or if the pregnant woman's decision-making capacity is questioned.

4.2g Summary

The purpose of the professional medical organizations' opinions and guidelines is to educate their members on handling situations of maternal-fetal conflict and pregnant women refusing treatment. All are dedicated to promoting the health of the pregnant woman and her fetus, along with a good outcome of the pregnancy for both. The five organizations all discuss technology resulting in the fetus' status as a patient for physicians. But they also acknowledge the fetus can only be treated through the pregnant woman with her consent. All five point out the fetus' total dependence on the pregnant woman for its growth and development. All the organizations believe it is inappropriate to compel treatment a pregnant woman refuses, including seeking court orders. Respecting the pregnant woman's legal rights and autonomy are central to these ethical opinions. Informed consent, communication, and education of the pregnant woman are considered essential.

The AMA and ACOG do give similar criteria for rare situations which may be an exception to compelling treatment. However, neither gives actual examples of clinical situations that fit their criteria. The RCOG gives lack of competence as the only reason to seek a court-order for treatment. FIGO is the only organization without any exceptions to their recommendations for respecting the pregnant woman's autonomous decisions. As the next section will discuss, actual physician views are not always consistent with those of professional medical organizations. Individual physicians in practice may interpret these guidelines differently. For example, minimal risk to the pregnant woman is not defined. This may mean a less than 1% risk of complications to one physician while another may interpret is as 2% risk of complications.

The Royal College of Physicians and Surgeons of Canada is the one exception to favoring respect for autonomy. They believe, unlike the other above organizations, that giving priority to the pregnant woman's autonomy is not adequate for resolving maternal-fetal conflict.[63] The RCPSC emphasizes balancing beneficence and autonomy. However, they give general approaches for dealing with maternal-fetal conflict but no specific guidelines. They do agree with the other organizations on the importance of counseling, education, fully informing the pregnant woman, and that the courts are not a proper venue to resolve maternal-fetal conflict. They call for establishing formal mechanisms to resolve situations of maternal-fetal conflict.

None of the organizations recommend ethics consults for help in resolving maternal-fetal conflict. ACOG recommended ethics consults in their 1987 committee opinion, but removed it at some point.[64] Ethics consults are a valuable resource to assist in resolving maternal-fetal conflict. They should be a part of all organizations' recommendations.

4.3 Research on Physician's Perceptions and Practices

A few studies were done over the years looking at physician views on maternal-fetal conflict and compelling treatment. The results do not necessarily match the above professional medical organizations' positions. However, these studies are descriptive as opposed to normative in nature, surveying physicians on their opinions concerning these topics.

4.3a Before Guidelines

In February 1986 Kolder, et al. conducted a national survey investigating "the scope and circumstances of court-ordered obstetrical procedures and solicited obstetricians opinions about this subject."[65] They sent a questionnaire to the heads of maternal-fetal medicine fellowship programs and to the directors of maternal-fetal medicine in ob/gyn residency programs.[66] Maternal-fetal medicine physicians are obstetricians who specialize in high-risk and complicated pregnancies. They obtained an 83% response rate of 75 physicians. Results showed thirty six occurrences in eighteen states and the District of Columbia seeking to overturn a pregnant woman's refusal of some type of treatment in the previous five years. Included were fifteen cases of seeking a court-ordered cesarean section in eleven states.[67]

Kolder, et al. also asked the physicians in charge of maternal-fetal medicine fellowships a specific set of questions concerning compelled treatment. The responses showed 46% "thought that mothers who refuse medical advice and thereby endangered the life of the fetus should be detained in hospitals or other facilities so that compliance could be ensured."[68] 47% responded "that the precedent set by the courts in cases requiring emergency cesarean sections for the sake of the fetus should be extended to include other procedures that are potentially lifesaving for the fetus, such as intrauterine transfusions, as these procedures come to represent the standard of care."[69] 26% "advocated state surveillance of women in the third trimester who stay outside the hospital system."[70] Only 24% consistently believed in upholding the pregnant woman's right to refuse medically advised treatment.[71]

Ellen J. Stein believes that the authors' point with the study was that "professionals are allowed the freedom perhaps to make mistakes of judgment in overusing technology under the protective umbrella of court-orders, but patients are denied the opportunity to make the opposite choice."[72]

The study was conducted before any of the professional medical organizations' documents on maternal-fetal conflict were released. United States obstetricians typically may be members of ACOG and/or the AMA. The AMA article was not published until 1990. ACOG's first committee opinion, "Patient Choice: Maternal-Fetal Conflict," was not published until 1987. No mention is made in the study as to how its results compared with the views of any professional medical organizations. The physician responses are consistent with legal and ethical practice at that time which favored protecting potential life and beneficence and nonmaleficence toward the fetus. The study does not discuss what legal or ethical principles physicians based their opinions on. Physicians' personal ethical and religious beliefs and values, along with the fear of being sued for malpractice if the fetus is harmed, are not examined. Neither is the ethics education physicians received. All of these factors would help illuminate reasons for the physicians' opinions.

4.3b After ACOG

Inspired by the Kolder, et al. study, Elkins, et al. surveyed 24 resident and 7 faculty physicians at the University of Michigan and Butterworth Hospital in Grand Rapids, MI. The study was published in Winter 1990, but no mention is made of when the actual study was conducted. Elkins, et al.'s study involved an anonymous questionnaire and discussion.[73] The study, however, differed from the Kolder study as to who was surveyed and the method used. The number of physicians surveyed was less

than half of those in the Kolder study. The survey gave the participants sample cases with questions about management of the cases.[74] The study did not ask about actual court orders sought.

One part of this study found physicians' willingness to seek judicial intervention when pregnant women refused treatment "in circumstances not involving delivery increased as fetal risk at term increased"[75] Highest results involved monitoring life-style behaviors such as alcohol intake and compliance with recommended insulin treatment for diabetics.[76] The study also found 26 physicians supported court-ordered cesarean sections. According to the authors this "increased as fetal risk grew to the point where fetal health was at grave risk without cesarean delivery."[77] Reasons were medical reasonableness by sixteen physicians, ethical principles by sixteen, and fourteen stated malpractice concerns. The physicians' answers also showed "that the ethical and social status of the fetus at term gestation is central to the management decisions of these cases and that medical tradition supports consideration of court-ordered intervention."[78] The Kolder study differed as it did not include reasons for physicians' views on compelling treatment.

The authors believed their results confirmed those of the Kolder, et al. study showing teaching hospital physicians are more willing to seek court-ordered interventions. The conclusion is flawed as Elkins only studied obstetricians at two hospitals. Neither Kolder nor Elkins surveyed obstetricians in non-teaching hospitals. Neither study presents data from non-teaching hospitals showing less willingness of physicians to seek court-ordered treatment.

The results did not support physicians' wanting to control their patients. Instead, willingness to intervene by physicians was based on the risk to the pregnant woman or her fetus.[79] The reasons for this were beneficence of physicians toward patients and the dilemmas faced due to having two separate patients – the fetus and the pregnant woman.[80] Adams, et al.'s comment on Elkins, et al.'s study is that "implied by this prioritization is support for coercive treatment of pregnant women in some circumstances."[81]

The study concluded that most obstetricians agree with ACOG's 1987 ethics committee opinion that "court-ordered interventions should 'almost never' be considered." But the authors also concluded "when faced in clinical settings with rare cases involving grave fetal risk at term gestation without similar maternal risk, they will often give higher priority to respect for fetal life, medical tradition, and beneficence than to maternal autonomy, bodily integrity, and privacy."[82] These last set of ethical principles are emphasized by ACOG. The 1987 committee opinion states "every reasonable effort should be made to protect the fetus, but the pregnant woman's autonomy should be respected" and "obstetricians should refrain from performing procedures that are unwanted by a pregnant woman."[83] Guidelines for seeking court intervention are not part of ACOG's 1987 committee opinion. The authors' conclusion about most obstetricians agreeing with ACOG is flawed. Obstetricians here agreed with ACOG only in certain circumstances and clearly disagreed in others as demonstrated in the second conclusion.

One can assume from the date of publication that, like the Kolder study, Elkin's study was conducted before any of the other organizations' guidelines were published. But the results of these two studies do demonstrate that the various professional medical

organizations possibly saw a need to respond not only to the court rulings but also to educate their members. As seen here, physicians' views differ greatly from ACOG's recommendations. Also, there is no way to know if the physicians involved in Elkin's study were aware of the final ruling of In Re A.C. and the shift in the court's thinking or how much weight they gave to the ruling. The study does illustrate that individual physicians are guided by their personal beliefs as opposed to ACOG's recommendations.

4.3c After Guidelines

In 2003 Adams et al. published their own survey of maternal-fetal medicine fellowship directors to determine whether opinions changed since the Kolder, et al. study and if physicians were still turning to legal interventions to force medical treatment of pregnant women.[84] The study is very similar to the Kolder study in the population surveyed and the method used. The study was the first one conducted after all the professional medical organizations published their documents on coerced treatment of pregnant woman. The study was also conducted after the courts increasingly ruled in support of the pregnant woman's autonomy and liberty rights.

70% or 42 fellowship directors responded to the survey which was less than in the Kolder study. The results included nine cases where court-orders were obtained to force treatment that the pregnant woman had refused, with "welfare of the fetus" as the reason in all cases and "welfare of the woman" as the reason in one case.[85] Despite a reduction in court-orders to compel treatment since Kolder, et al.'s study, Adams et al.'s data showed physicians still seek them when there is conflict over delivery of a near term fetus.[86] Adams, et al. also found that 4% of those surveyed believed in compelling pregnant women to have maternal-fetal surgery, submit to intrauterine transfusions, or

detain noncompliant diabetics. 8% believed in detaining pregnant women who are substance abusers or monitoring pregnant women outside the hospital system.[87] These results are 43% less than in 1987. The majority of physicians' views here are in line with all of the professional medical organizations' documents that support respecting autonomy and not coercing treatment.

Despite the drop in those favoring forced treatment, Adams, et al. write that "they still reflect a 'disconnect' between the recommendations of medical organizations and the attitudes of many clinicians" and "wonder whether these organizations are expressing 'politically correct' views as articulated by their leadership, rather than the view of their members at large."[88] The authors believe that this may result in a difference between what physicians state and how they actually practice due to their diverse views on the moral status of fetuses and their duties to them. They also write:

> many physicians are more troubled by pregnant women's refusal of treatment when the fetus is close to term than they are earlier in gestation. They are also more troubled when the treatment refused is 'standard of care,' when it entails little risk to the woman, and when it is highly likely to prevent severe damage to the potential child.[89]

But they state that ethically, practitioners may be troubled by inconsistencies in respecting the autonomy of pregnant and non-pregnant women.[90] However, Adams, et al.'s above conclusions do not include data to support them. They are speculation and opinions of the authors. The conclusions should be studied to see if they are correct.

Only about one to four physicians out of 42 disagreed with the organizations' recommendations in Adams' study. Adams, et al. may be unrealistic in expecting all of the physicians surveyed to agree with the professional organizations' opinions given the diversity of physicians' views. The numbers do represent a significant change from

sixteen years prior. But, like Kolder, this study did not inquire as to the reasoning, ethical or otherwise, behind the physicians' views. None of the three studies inquired as to the sources for physicians' opinions in terms of religious beliefs or ethics education. The next study conducted on this subject in the United States should include obstetricians' opinions and reasons for them, such as considering the fetus a patient, fear of malpractice lawsuits, or favoring beneficence over autonomy. The number of obstetricians who are actually influenced by ACOG's or the AMA's guidelines can also be examined.

4.3d European Stance

A study published in 2006 by Cuttini, et al. presented the views of obstetricians from eight European countries in 2001 - 2002 on a fictitious case of refusal of cesarean section for acute fetal distress.[91] The study was much larger with 1530 obstetricians participating and closer to the Elkins study in terms of the method used. The results were not uniform in the eight countries except for the fact that most obstetricians believe in trying to persuade the pregnant woman to have the cesarean section. However, Spanish, French, Italian, German, and Luxembourg obstetricians supported seeking court intervention to protect the fetus, avoid legal liability, or both. A smaller percentage of obstetricians in the United Kingdom, Sweden, and the Netherlands agree with this approach.[92]

Cuttini, et al. attributed these findings to differences in law and ethical attitudes between the countries and differences in professional and personal characteristics of obstetricians within countries.[93] The authors concluded that persuasion, not manipulation or coercion, is the least controversial option with a competent patient.[94] They also concluded that case law and professional guidelines have not resolved differences in

individual physician beliefs.[95] They reference ACOG, AMA, RCPSC, and RCOG guidelines, but they do not examine how many obstetricians belong to these organizations or are familiar with their recommendations. They do not mention FIGO. Legal cases of court-ordered cesarean sections in the various countries are not discussed.

The study, however, does examine other variables that the three previous studies did not. The authors found younger age and personal values, such as being less religious or being married, led to greater acceptance of the pregnant woman's refusal of treatment.[96] Answers were also consistent with individual countries' laws concerning the status of the fetus. French physicians favored beneficence over autonomy which is the common belief in France.[97]

As these results demonstrate, cultural and national origin influences physicians' ethical views. These differences are not necessarily reflected in professional medical organizations' statements which reflect the predominant views of their country of origin. Differences in religious beliefs are also not considered by the professional organizations. The above results, along with the view of the fetus as a separate patient, go a long way in explaining the disconnect between professional medical organizations' guidelines and actual physician beliefs. Individual physician beliefs illustrate the inconsistencies found in legal, philosophical, and religious normative theories that are not reflected in professional medical organizations' recommendations.

4.3e Studies and Organizational Views

As the above studies show, there is increased consistency between the positions of major medical organizations and individual physicians concerning handling situations of maternal-fetal conflict. The percentage of physicians who disagreed with the major

medical organizations decreased from 46-47% in Kolder, et al.'s survey in 1986 to 4-8% in Adams et al.'s study in 2003. Major professional organizations' opinions and guidelines are usually based on the recommendations of their ethics committees that consist of physicians, philosophers, theologians, and others. The ethics committees look at the ethics literature and recommendations of ethics experts in the area they are examining. They typically do not survey their members to find the majority view as part of developing the documents. The guidelines and opinions are normative educational guides and recommendations for the members concerning ethical issues. Therefore, not all physicians agree with these organizations' positions due to the large number of members and the diversity of religious, cultural, and moral values and beliefs among them. As the above studies showed, some physicians are motivated to seek to compel treatment based on beneficence and their duty toward the fetus as a separate patient as opposed to respecting the pregnant woman's autonomy and legal rights. Compelling treatment is highest when term fetuses are involved and the risks to the fetuses are high. The physicians believe these ethical theories are a priority based on their own beliefs and views rather than following the recommendations of the professional medical organizations.

None of the studies asked the physicians and residents if they were members of any professional medical organizations. Membership in professional medical organizations is voluntary and not required for medical licensing and board certification. Not all physicians choose to join these organizations and therefore may not be familiar with the different organizations' literature. If they are a member, they still may not be familiar with all of the educational materials and recommendations of the organizations.

Since these documents are guidelines and opinions, there are no punishments or penalties for physicians who do not follow them.

What physicians actually do when they encounter a situation of maternal-fetal conflict in their own practice is uncertain, though many base their actions on their personal moral beliefs according to these studies. Personal moral beliefs are influenced by the physicians' religious, social, and cultural beliefs as shown in the Cuttini, et al. study. Fear of being sued for malpractice if the fetus suffers harm or dies as a result of respecting the pregnant woman's autonomous decision is high among obstetricians. The fear of lawsuits influences individual physician responses to maternal-fetal conflict. Physician behavior is also influenced by different countries laws concerning the status of the fetus. Whether physicians actually follow in practice the answers they give in response to these surveys is unknown. Also, the Kolder and Adams studies done in the United States did not survey general obstetricians in practice but maternal-fetal medicine specialists in academic settings. These responses may not reflect the views of all practicing general obstetricians. A large study of practicing obstetricians and residents in all parts of the country concerning this subject is needed.

Despite improvement in the alignment of individual physicians' views with the recommendations of major professional organizations, inconsistencies still exist and reflect the inconsistencies found in legal, philosophical, and religious normative theories. Given the inconsistencies in legal and ethical normative theories, it may be unrealistic to expect all physicians to agree with the recommendations of the professional medical organizations. The only way to accurately determine how close actual physicians'

practices align with the positions of the major medical organizations is to actually document all cases of maternal-fetal conflict that occur and how the conflict is resolved.

4.4 Fetus as Patient

One of the possible reasons cited for the above differences between physicians and professional medical organizations' positions on maternal-fetal conflict is how the fetus is viewed. There are two ways to view the maternal-fetal relationship – the one-patient and the two-patient model.[98]

4.4a One-Patient Model

The pregnant woman and her fetus were traditionally treated using the one-patient model.[99] The fetus in this model is a part of the pregnant woman. The two are referred to as the "maternal-fetal dyad."[100] In this model, harms and risks to the pregnant woman are balanced with benefits to the fetus. The fetus and pregnant woman are treated as one ethically and medically by the physician, with the pregnant woman making decisions for her and her fetus.[101] In this model, the pregnant woman can refuse treatment, including a cesarean section, based on her assessment of risks and benefits to her and her fetus under informed consent.[102] But Carol Tauer believes that in exceptional circumstances where there is near certainty of serious harm to the fetus and benefit to the pregnant woman, the pregnant woman has a moral obligation to accept treatment. However, forcing treatment is paternalistic and not justifiable in the case of a competent pregnant woman.[103]

Susan Mattingly believes that the traditional one-patient model resulted from the inability to directly examine or visualize the fetus. Management of any suspected fetal anomalies consisted of treating the maternal environment.[104] She states physicians

viewed this "maternal-fetal dyad as one complex patient, the gravid female, of which the fetus was an integral part."[105] Under the single patient model, if conflict occurs, it is within the patient, not between two different patients. The conflict is settled through the principle of beneficence by the physician. If the burdens of treatment to the pregnant woman and her fetus are small and the benefits to the fetus are great, then beneficence requires the physician to recommend treatment.[106] Mattingly points out that the argument sometimes used to compel treatment, that the pregnant woman is causing harm to the fetus, does not apply with the one-patient model as the pregnant woman is only causing harm to herself.[107]

The one-patient model is the model applied by professional medical organizations to maternal-fetal conflict. The fetus and the pregnant woman are treated as one individual for whom the pregnant woman makes decisions. The pregnant woman and her physician must balance risks and benefits to the pregnant woman and her fetus when considering medical care and treatment for one or both.

4.4b Changes in the Fetus' Status

Advances in obstetrical care brought about changes to the traditional one-patient view of the pregnant woman and her fetus. Changes began in the 1950's with the ability to diagnose and treat fetal hemolytic anemia. According to Carl P. Weiner, this was the start of primary care fetal medicine.[108] In the 1970's the fetus became a patient in obstetrics with fetal imaging leading to the elevation of the moral status of the fetus.[109] Studies from the 1980's show that parents' visualizing their fetus by ultrasound accelerated bonding with the fetus. Other studies showed visualization of the fetus by ultrasound increased maternal compliance with recommended treatment.[110] Referring to

the fetus, Byron C. Calhoun observes, "the most recent real-time 3D/4D ultrasounds now produce scans so life-like and human-like that no one can mistake them for anything but a baby."[111]

Besides ultrasound, other diagnostic tools and treatments specifically directed toward the fetus include amniocentesis and chorionic villus sampling.[112] Other procedures include non-invasive fetal monitoring, fetal blood transfusions, and in-utero fetal surgery.[113] Nancy Milliken in The Encyclopedia of Bioethics points out that this technology has changed:

> medicine's conception of the fetus. No longer is the fetus defined predominantly as a part of the pregnant woman, but rather as a distinct entity that can be the independent focus of diagnostic tests and individual therapies. 'A second patient with many rights and privileges comparable to those previously achieved only after birth.' It is the widely shared view of obstetricians that the fetus is a patient to whom they owe ethical duties.[114]

The fetus is now in direct competition with the pregnant woman, making her body an obstacle to diagnosing and treating the fetus.[115] Since the fetus is viewed as a separate patient, Constance Perry believes "healthcare professionals have a duty to protect, even promote, its well-being."[116]

The idea of the fetus as a separate patient is reflected in the obstetric subspecialty of maternal-fetal medicine and the development of fetal care centers. Examples include The Center for Fetal Diagnosis and Treatment at the Children's Hospital of Philadelphia which advertises itself as "the world's first birth facility devoted exclusively to women carrying fetuses with diagnosed birth defects."[117] NAFTNet, the North American Fetal Therapy Network, has a web site promoting itself as "a voluntary association of medical centers in the United States and Canada with established expertise in fetal surgery and

other forms of multidisciplinary care for complex disorders of the fetus."[118] NAFTNet describes fetal medicine as:

> the branch of medicine that includes the assessment of fetal growth and well-being, the maintenance of fetal health and the diagnosis of fetal illness and abnormalities. As prenatal diagnosis has improved, so has our capability to diagnose problems before birth. Therefore, the fetus is increasingly becoming an independent individual, and fetal medicine is the specialty that addresses this 'unborn patient."[119]

According to NAFTNet there are two branches of fetal medicine – prenatal diagnosis and fetal treatment.

However, the site does not mention the pregnant woman or her role in fetal diagnosis or therapy. The organization is strictly dedicated to the diagnosis and treatment of fetal disorders and ignores the fact that the pregnant woman's informed consent and voluntary participation are necessary for fetal diagnosis and treatment. The fetus is not an independent individual in any sense. The fetus cannot make any autonomous decisions concerning its medical care and treatment. There is no way to communicate with the fetus. Also, the fetus cannot go to see a physician on its own. The fetus is dependent on the pregnant woman to seek and make decisions concerning its medical care and treatment. These facts have been overlooked as technology has changed physicians' views of the fetus.

4.4c Two-Patient Model

The change in the perceived status of the fetus results in a two-patient model for obstetrics that focuses, according to Tauer, "more on fetal well-being because it views the fetus as a distinct individual and patient."[120] Mattingly observes that "elevation of the fetus to patient status has occurred not because of any change in the fetus or in the

maternal-fetal relationship but because of a change in physicians - in how they think about and relate to their patients during pregnancy."[121]

The two-patient model leads to the problem of balancing benefits and harms to the fetus with benefits and harms to the pregnant woman and the potential for maternal-fetal conflict. Consent must be obtained from the pregnant woman in order to diagnose or treat the fetus, as ethically and legally one person cannot be forced to be at risk for harm for the sake of another.[122] However, Tauer believes the two-patient model, unlike the one-patient, allows for overriding the pregnant woman's autonomous refusal of treatment in exceptional circumstances on a moral basis.[123] When a course of action is recommended that prevents serious harm to both the fetus and the pregnant woman the pregnant woman's refusal can be ignored. She states this is justified by the limits of autonomy since the pregnant woman's refusal of treatment causes harm to another – the fetus.[124] She writes:

> the pregnant woman could ostensibly refuse treatment if she were the only one at risk of being harmed. But she does not have the right to harm another by refusing treatment that is also beneficial to her. In this situation, intervention promoting the welfare of a vulnerable individual (the fetus) while actually benefiting a second individual (the woman) is ethically justifiable.[125]

But if there is no benefit to the pregnant woman, overriding her refusal of treatment is not justified for Tauer.[126]

With the two-patient model what is best for each patient must be considered individually, not as one patient. Problems are created when treatment that benefits one patient does not benefit the other, yet will affect both patients.[127] Balancing harms and benefits as with the one-patient model does not apply here. Neither does beneficence since it does not allow for balancing benefits to one with benefits to another.[128] Mattingly

advises that obstetricians can recommend treatment beneficial to the fetus, but only invite the pregnant woman to voluntarily undergo the treatment when it is not beneficial to her.[129]

McCullough and Chervenak believe that the viable fetus becomes a patient, independent of the autonomous pregnant woman granting this status, when:

> it is presented to the physician and there exists clinical interventions that are reliably expected to result in a greater balance of clinical good over clinical harm for the fetus and the child it can become. The pre-viable fetus is a patient solely as a function of the pregnant woman's autonomous decision to confer this moral status.[130]

Their view once again ignores the fact that the pregnant woman must make the decision to present the viable fetus for treatment, as the fetus is not capable of presenting itself. The viable fetus may have independent moral status, but as stated previously, the fetus is not capable of acting independently in any manner. The pregnant woman's voluntary participation is necessary for the fetus to be a patient. Any other patient who lacks decision-making capacity can be treated with the consent of a surrogate or guardian without physically treating the surrogate or guardian also. The fetus is unique in that physical treatment of the fetus can only occur through the pregnant woman. Therefore, the fetus cannot be a patient independent of the pregnant woman.

Lyerly and Mahowald write that the fetus as a patient is a misconception as the fetus is never physically separate from the pregnant woman. Once separate from the pregnant woman, it is something other than a fetus.[131] The fetus as a separate patient leads to, as discussed earlier, diverging interests and conflicts as opposed to converging interests under the one-patient model.[132] They write that a patient is usually an individual,

which a fetus is not. Therefore, fetuses are not patients. They believe the pregnant woman is the only patient present, of which the fetus is a part.[133]

4.4d Summary

The view of the fetus as a patient changed over time for physicians due to the development of technologies that allow visualization, diagnosis, and treatment of the fetus. An entire specialty of fetal medicine emerged as a result of these technologies. The two-patient model also changed individual obstetrician's ethical views on the fetus as a patient. The model, however, is not consistent with the positions of the major medical organizations concerning maternal-fetal conflict. Professional medical organizations use the traditional one-patient model, supporting the pregnant woman's right to make decisions for her and/or her fetus. The pregnant woman and fetus are treated as a unit in the one-patient model.

Physicians who believe that the fetus is an independent patient and use the two-patient model may find it creates more conflict and does not provide a way to resolve maternal-fetal conflict. Physicians viewing the pregnant woman and the fetus as separate patients support the findings of physician surveys that favor court-ordered treatment when the pregnant woman refuses treatment beneficial to her and/or her fetus. Therefore, inconsistencies exist between the opinions and guidelines of the professional medical organizations and what is being taught to and believed by physicians caring for fetuses and pregnant women in terms of who is their patient and obligations to them. Whether the gap between these two positions will widen again as more technology, treatments, and specialty centers devoted primarily to the fetus as a patient are developed is unknown, but is likely. Obstetricians' concerns over lawsuits from not offering diagnosis and treatment

for the fetus may also increase and change physicians' beliefs and behaviors. These areas may influence actual practicing obstetricians' ethical views more so than other normative ethical theories and approaches, including the recommendations of professional medical organizations.

4.5 Cesarean Delivery on Maternal Request

Another change that has occurred among obstetricians is the increasing acceptance of cesarean delivery on maternal request without a medical indication.

4.5a Definition and Incidence

Cesarean delivery on maternal request is defined by ACOG's Committee on Obstetrical Practice "as a primary cesarean delivery at maternal request in the absence of any medical or obstetrical indication."[134] Hale and Harer use the term "elective prophylactic cesarean delivery" and define it as "a cesarean delivery done at 39-40 weeks of gestation for the preservation of health or the prevention of injury either to mother or child or both."[135] Cesarean delivery on maternal request was initially suggested in 1985 due to the worsening medical-legal climate.[136] Hale and Harer believe acceptance of the procedure increased due to "publicity regarding the potential for maternal pelvic injury and fetal injury from a trial of labor for vaginal delivery and modern acceptance of the mother's right to autonomy."[137] The original purpose of cesarean section is to save the pregnant woman's life. Later, saving the fetus' life, reducing the fetus' risk of neurological injury, and preserving the pregnant woman's anatomy became additional reasons for performing cesarean sections.[138]

The overall rate of cesarean section in the United States was 30.2% of live births, over 1.2 million, in 2005. Due to the lack of specific information, such as coding and documentation, accurate rates of cesarean delivery on maternal request are uncertain but thought to be about 2.5% of all births or about 4-18% of all cesarean sections.[139] Reasons for pregnant women requesting cesarean delivery are control of one's life, convenience, fear of labor pain, fear of death, to prevent fetal injury, and to avoid damage to pelvic floor muscles.[140] Other countries also changed their attitudes toward cesarean delivery, with Brazil having one of the highest rates overall. The rate of cesarean delivery on maternal request is 9% in Italy, with one region mandating its availability by law.[141] Surveys of obstetricians from other countries show 62% to 81% of the obstetricians offer and perform cesarean delivery on maternal request. In the United States, 59% of obstetricians responded in a survey that they perform cesarean delivery on maternal request.[142]

4.5b Scientific and Ethical Issues

No good data or studies exist to scientifically support this shift in obstetricians' view of cesarean delivery from a medically indicated procedure to an elective delivery option for pregnant women. James Scott observes "there are no randomized controlled trials and few prospective long-term studies to show that the benefits of requested elective cesarean delivery outweigh the risks compared with vaginal delivery."[143] On March 27-29, 2006 the National Institute of Child Health and Human Development and the Office of Medical Applications held a State of the Science Conference on Cesarean Delivery on Maternal Request.[144] The independent panel heard expert presentations and reviewed all studies on the subject. The panel concluded "there is insufficient evidence to

evaluate fully the benefits and risks of cesarean delivery on maternal request versus planned vaginal delivery, and more research is needed."[145]

Another conclusion reached by the panel was "until quality evidence becomes available, any decision to perform a cesarean delivery on maternal request should be carefully individualized and consistent with ethical practices."[146] Factors to consider include weight, age, future reproductive plans, gestational age, cultural and personal values, and life experiences.[147] Ethical issues involved include the autonomy of the pregnant woman. But the negative right to refuse treatment is almost absolute but the positive right of requesting a procedure is not.[148] Therefore, no absolute right to cesarean delivery on maternal request exists for a pregnant woman. Also, the pregnant woman must be fully informed of all risks and benefits of the procedure in a nondirective manner. Individual factors must be taken into consideration and concerns underlying the request must be addressed.[149] Decision-making should be a shared process between the patient and her physician.

4.5c Physician and Organizational Views

Once again, inconsistencies exist between the positions of major medical organizations and those of individual physicians. As stated previously, surveys of obstetricians show the majority perform cesarean delivery on maternal request, even though scientific evidence does not exist to support doing so. Physicians' reasons are acceptance of the pregnant woman's autonomy in choosing her route of delivery and lawsuit concerns, especially if there can be complications from a vaginal delivery that may be avoided by cesarean section. Whether keeping patients happy so they will not leave an obstetrician who refuses to perform a cesarean section for one who will do what

the patient wants is not known, but is another possible reason. ACOG's Committee on Ethics justifies cesarean section on maternal request only if the health benefits of cesarean section outweigh those of vaginal delivery.[150] The Society of Obstetricians and Gynecologists of Canada states "vaginal birth remains the preferred and safest option."[151] The Royal College of Obstetricians and Gynecologists do not believe maternal request alone is an indication for cesarean delivery and the International Federation of Gynecology and Obstetrics believes it is "not ethically justified."[152]

As shown above, a majority of obstetricians no longer view cesarean delivery as a procedure reserved for specific medical situations. Instead, they view it as an acceptable alternative to a planned vaginal delivery. Physicians are not viewing cesarean delivery as a high risk procedure. Cesarean section rates continue to increase in this country. These factors may lead physicians to believe cesarean delivery is a low risk, routine procedure that a pregnant woman should not refuse when the benefits and prevention of harm to the fetus outweigh the risks to the pregnant woman, especially when many pregnant women are requesting cesarean delivery as an elective route of delivery. Combining this with viewing the fetus as a separate patient to whom they have obligations may explain why individual physician views on maternal-fetal conflict are not consistent with those of professional medical organizations. These factors may also explain why some physicians believe it is acceptable to seek a court-order to compel a pregnant woman to undergo a cesarean section to benefit her fetus when the risk to her is minimal.

4.6 Conclusion

Professional views do not give a consistent answer when applied to a situation of maternal-fetal conflict. Professional medical organizations' official ethics guidelines and

opinions are normative, based on moral theories and ethics research and view the maternal-fetal dyad as one-patient. Their guidelines and opinions uphold the pregnant woman's right to make decisions concerning her and/or her fetus' medical care and treatment. Only in very rare circumstances when specific conditions are met does ACOG and the AMA advocate seeking court orders to compel treatment a pregnant woman has refused. But these conditions are vague and subject to interpretation. The RCPSC recommends balancing autonomy and beneficence, but not coercion or seeking court orders.

However, many obstetricians view the fetus and pregnant woman as two separate, individual patients. The two-patient view is increasingly embraced due to the development of treatments solely for the fetus' benefit. Descriptive studies show not all obstetricians agree with the professional organizations' positions, with some supporting court-ordered intervention. These physicians believe beneficence and duties toward the fetus as a separate patient take precedence over the pregnant woman's autonomy. Fear of being sued for malpractice also contributes to the adoption of two-patient model. These views are more prevalent as the fetus approaches term and the risk of harm to the fetus increases. They result from the diversity of personal moral views of individual obstetricians which may not match the ethical recommendations found in the literature. However, these views are decreasing over time with more obstetricians stating that respecting the pregnant woman's autonomy is primary. The number of court cases also decreased over time according to these studies. But these studies are small and not representative of the entire country or all obstetricians. Actual numbers on the views of all obstetricians or a wider sample of obstetricians concerning compelled treatment are

not available and perhaps may be done in the future. Whether all obstetricians will answer honestly or simply say what they believe their answer should be as opposed to what they will actually do in practice is unknown.

Obstetricians' view of the role of cesarean section also changed. Despite a lack of scientific evidence to support cesarean delivery on maternal request, obstetricians are increasingly using it as an acceptable alternative to planned vaginal delivery. The overall rate of cesarean section, elective and non-elective, continues to increase. These changes may lead obstetricians to view the surgery as a routine, low risk procedure that patients should not refuse when benefits outweigh the risks. These changes may also contribute to the differences between actual practicing obstetricians and professional medical organizations' views.

Unfortunately, the inconsistencies in legal, philosophical, and professional views of maternal-fetal conflict will not be resolved by examining religious views of maternal-fetal conflict. For example, inconsistencies exist between Catholic, Jewish, and Islamic views of the fetus and the pregnant woman's moral obligations to the fetus, as will be discussed in the next chapter.

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Chapter 5

Religious Moral Treatment of Maternal-Fetal Conflict

5.1 Introduction

Religious moral teachings used to resolve maternal-fetal conflict do not overcome the inconsistencies seen in legal, philosophical, and professional medical organizations' normative theories and approaches. The three religions to be considered in this chapter, Roman Catholicism, Judaism, and Islam, do not have a consistent normative moral theory that can be used to resolve situations of maternal-fetal conflict. The chapter examines the different religions' normative moral theories on sanctity of life, autonomy of the pregnant woman, the status of the fetus, and abortion. Other moral teachings that can be applied to situations of maternal-fetal conflict, such as love of neighbor and stewardship, are also discussed.

The three religions differ in the sources of their moral teachings. Roman Catholicism has a central magisterium which puts forth the official teachings and moral theories of the Church that all members should follow. These are based on reason, experience, scripture, and tradition.[1] The teachings and moral theories are the basis for the Ethical and Religious Directives for Catholic Health Care Services which guide

Catholic hospitals and health care in the United States. Judaism, unlike Catholicism, does not have a central magisterium or one central teaching on ethical matters. The three major branches of Judaism, Orthodox, Conservative, and Reform, can all have different views concerning the same ethical issue and give different weight to tradition, law, and autonomy. Islam is a religion with a diversity of bioethical views due to the different schools, sects, and cultures within Islam.[2] The two sects are the Sunnis and the Shi'ites. The Sunni sect has four schools or interpretations. The schools are the Malaki, Hanafi, Hanbali, and Safi'i.[3] Islam has no clergy or central authority, as the Catholic Church does, to state the entire religion's or Muslim community's one position on any matter.[4] Islam is similar to Judaism in this way. The lack of a central authority means different schools and sects can follow dissimilar codes, resulting in different interpretations of the faith.[5]

5.2 Sanctity of Life and Status of the Fetus

Roman Catholicism, Judaism, and Islam are consistent in believing that all human life is sacred and has dignity and worth. The three religions, however, are not consistent in their beliefs as to when the fetus becomes a person.

5.2a Catholic

The Roman Catholic Church teaches that human life must be respected from the moment of conception.[6] The Church's "Declaration on Procured Abortion" states "the tradition of the Church has always held that human life must be protected and favored from the beginning, just as at the various stages of its development."[7] The teaching is consistent throughout the Church's history and is the basis for the Church's position

against direct abortion. According to "The Declaration on Procured Abortion," "the first right of the human person is his life."[8] The teaching is reiterated in the Sacred Congregation for the Doctrine of the Faith's "Instruction on Respect for Human Life in its Origin." The document states "the human being is to be respected and treated as a person from the moment of conception and therefore, from that same moment its rights as a person must be recognized, among which in the first place is the inviolable right of every innocent human being to life."[9] The teaching was upheld in 2006 by Pope Benedict XVI who stated embryos, even when they consist of only a few cells in or out of the woman's body, have the same right to life as other humans born or unborn.[10] Concerning the Catholic Church's traditional position, E. Clinton Gardener believes the:

> fundamental concern is to protect the sanctity of life… Embryonic and fetal life are fully human from the moment of conception and are, therefore, entitled to the same protection as any other life.[11]

However, the Church never officially claimed that conception is when the soul is created.[12] According to "The Declaration on Procured Abortion":

> This declaration expressly leaves aside the question of the moment when the spiritual soul is infused. There is not a unanimous tradition on this point and authors are as yet in disagreement.[13]

Humans are created in the image and likeness of God, which gives a person value, an orientation toward forming a relationship with God, and dignity.[14] J. D. Cassidy articulates this as:

> The Catholic Church teaches that persons alone are called to share, by knowledge and love, in God's own life. It is for this end that she or he was created, and this is the fundamental reason for his or her dignity.[15]

Since God created life, it is sacred from the start. Human life is a gift from God. God, not man, is the "Lord of life" and determines life's beginning and end.[16] All human

life is sacred and has intrinsic value at all stages of development.[17] The teachings are found in the Sacred Congregation for the Doctrine of the Faith's "Instruction on Respect for Human Life in its Origin" which states "from the moment of conception, the life of every human being is to be respected in an absolute way because man is the only creature on earth that God has 'wished for himself' and the spiritual soul of each man is 'immediately created' by God."[18]

The Catholic Church's teachings on the beginning of human life and sanctity of life give the fetus and the pregnant woman the same status. Their lives are both sacred, having the same dignity and inherent value. Elio Sgreccia believes "the person is valuable for what he is, and this value is permanent from the moment of conception to the moment of death and beyond death."[19] One life is not worth more than another. The teaching is not the same as the state's interest in protecting the potential or future life of the fetus or the philosophical view of the pregnant woman's duty to the fetus because it will be her future child. The fetus is not a potential or future life according to Catholic teaching. The fetus is as much of a person as the pregnant woman. The teachings form the basis for the Church's views on the pregnant woman's moral obligations to her fetus and should guide her decisions and actions during her pregnancy.

5.2b Jewish

Sanctity of life is of supreme value in Judaism. Life in this world, regardless of its quality, is to be valued.[20] Judaism teaches all life has dignity and value since all are created equal in the image of God.[21] These teachings are similar to Catholic teaching. The obligation of pikkuah nefesh requires Jews to set aside Sabbath laws and all other Jewish laws except three to save a life. The three exceptions are laws against murder, idolatry,

and adultery/incest.[22] According to David Feldman, "as important as is proper ritual observance of Sabbath, Yom Kippur, or dietary laws, they all take second place to proper care of the fundamentals of physical health."[23] Abramo Piatelli's opinion is in Judaism "nothing in this world has greater value and greater moral importance than human life."[24] He states this is seen in the Talmudic maxim "saving a life is the same as saving the whole world."[25] According to Fred Rosner, an Orthodox author, Maimonides ruled "if a woman dies in labor, it is permissible and perhaps mandatory to perform an immediate cesarean section in an attempt to save the baby."[26]

Judaism teaches that God is the author of all human life. God's power creates the fetus and brings it to full life. Only God gives life and takes it away, not individuals.[27] These teachings are the same as Catholicism. Some of the prophets of Israel believed they were formed by God in their mother's womb since God had a special purpose for them.[28] Jeremiah 1:15 says "Before I formed thee, in the belly I knew thee." The verse refers to God's relationship with Jeremiah as a fetus. Psalm 139:13-16 refers to David's "unformed substance in the womb interacting with God."[29] If one believes these teachings, the fetus is to be valued. The fetus is a creation of God that has a special relationship with God even before birth. The teachings morally obligate the pregnant woman to undergo the cesarean section as the fetus' life is valued due to its direct relationship with God in the womb and the belief that only God can decide when to begin and end life.

The Encyclopedia of Jewish Medical Ethics, an Orthodox publication, states that:

> There is no obligation to save the life of an unborn fetus, and the law of killing a fetus is not on par with the killing of a newborn. Nevertheless, it is permitted to desecrate the Sabbath to save an unborn fetus, not because

> of the obligation of saving a life but because of the dictum 'desecrate one Sabbath now so that the fetus will later observe many Sabbaths.'
>
> Some Rabbis do not obligate a woman to undergo Cesarean section to save the life of her fetus or to prevent harm from it. The reason is that one is not obliged to endanger oneself on behalf of another. Other Rabbis require her to do so unless the fetus has major defects which make it doubtful as to whether it will survive after birth. The reason is that a woman is obligated to have children for her husband and the danger of Cesarean section is minimal.[30]

The above teaching that the pregnant woman is not obliged to endanger herself on behalf of the fetus does not necessarily apply in this situation. Having the cesarean section does not endanger the pregnant woman's life, unless the pregnant woman truly believes her life is at risk by undergoing the surgery.

Unlike Catholicism, halakhah does not teach that the fetus is to be treated as a person with full human rights equal to the pregnant woman. Feldman gives the Talmud teaching "the fetus is deemed a 'part of the mother,' rather than an independent entity."[31] The teaching refers to ownership and legal status of the embryo.[32] The fetus prior to forty days is considered simply water. After forty days it is a part of the pregnant woman, "the thigh of its mother."[33] The fetus is considered a potential human with a lesser status than the pregnant woman.[34] All Jewish authorities and branches agree on this. Halakhah teaches that a fetus becomes a person at birth.[35] Once the fetus' head has emerged during a vaginal delivery, or some Rabbis teach as long as the fetus is in the birth canal, or with a breech delivery if the greater part of the fetus' body has delivered, the fetus is considered a full person with rights equal to the mother.[36] According to Davis, the teaching is based on the passage Mishnan Oholot 7:6:

> if a woman is having difficulty giving birth, one cuts up the fetus within her and takes it out limb by limb because her life takes precedence over its

> life. Once the greater part has emerged, you do not touch it, because you may not set aside one life for another.[37]

Both lives are equally important once the fetus becomes a person. The Schulchan Aruch teaches "we do not dispose of (or push aside) one person in favor of another."[38]

Based on the above teachings, the pregnant woman prior to the birth of the child has a greater right to life than the fetus. Judaism differs greatly from Catholicism which teaches that since the fetus is to be treated as a person from the moment of conception, it has the same rights as a person starting from conception, giving the pregnant woman and fetus an equal right to life.[39] Zahara Davidowitz-Farkas and Joseph Finns articulate this as:

> halakhically, placing the interests of the fetus over that of the mother is generally contrary to Judaism's understanding of the fetus' status which is not considered a life. For this reason, as well as to promote the integrity of the family unit, medical decisions are made for the sake of the mother and not the fetus.[40]

The teachings concerning the status of the fetus as a person in Judaism by themselves may not be sufficient to morally obligate the pregnant woman to undergo the cesarean section in this case. Medical decisions are made from the pregnant woman's perspective and not the fetus', so the risks to the pregnant woman's life and health are primary over the risks to the fetus. These teachings must also be weighed against the sanctity of the fetus' life which is valued due to its direct relationship with God in the womb and the belief that God decides when to begin and end life.

5.2c Islamic

Similar to Catholicism and Judaism, every moment of human life is sacred and has value in Islam, regardless of the quality. There is a duty in Islam to save life and it is

a sin to take a life.[41] God is the origin of human life. According to Osman Bakar, "human beings are God's noblest creatures by virtue of the fact that he has breathed his spirit into every human body, male and female, at a certain stage of its embryological development."[42] All life is to be respected.[43] Each human life is unique and considered irreplaceable in Islam.[44] Protecting human life is one of five basic human rights found in the Sharia or Islamic law. The duty to protect life is found in the Quran. According to Oren Asman:

> One who kills a person not in retaliation for murder, or to avoid mischief in the land; it is as if he killed all mankind. One who saves a life, it is as if he saved the life of all mankind.[45]

The Quran describes the process of fetal development, beginning as an organism and ending as a human.[46] Verse 39:6 states:

> He creates you in the wombs of you mothers
> In stages, one after another
> In three veils of darkness
> Such is Allah, your Lord and Cherisher[47]

There are two other verses of the Quran, 22:4 and 23:12-14, that describe the stages of fetal development.[48] Verse 22:4 says:

> O MEN! If you are in doubt as to the [truth of] resurrection, [remember that,] verily, We have created [every one of] you out of dust, then out of a drop of sperm, then out of a germ-cell, then out of an embryonic lump complete [in itself] and yet incomplete, so that We might make [your origin] clear unto you.[49]

Verse 23:12-14 states:

> NOW INDEED, We create man out of the essence of clay, and then We cause him to remain as a drop of sperm in [the womb's] firm keeping, and then We create out of the drop of sperm a germ-cell, and then We create out of the germ-cell an embryonic lump, and then We create within the embryonic lump bones, and then We clothe the bones with flesh – and then We bring [all] this into being as a new creation: hallowed, therefore, is God, the best of artisans![50]

The above four stages of embryonic development spelled out in the Quran are, according to Nazeen Goolam:

> (1) Nutfah: literally meaning a drop of fluid;
> (2) Alakah: literally meaning something that clings and adheres to the womb. This describes the implantation stage;
> (3) Modgha: literally meaning a piece of flesh that has been chewed; and
> (4) Formation of bone and flesh from Modgha: The Qur'an clearly states that the 'Modgha' is transformed into bone and the bones are then covered by flesh.
> The final stage in the development of the fetus is, just as in Christianity, ensoulment of the entity of the soul into the fetus.[51]

Hadith, or tradition, teaches that the three stages of nutfah, alakah, and modgha each last forty days. Ensoulment occurs at 120 days of gestation when "an angel is sent to breathe the soul' into the fetus."[52] However, a few scholars believe ensoulment occurs when the fetus begins voluntary movements.[53]

Islam views the fetus as a progressively maturing person with legal rights from conception until it is born. The fetus is considered a separate entity from the pregnant woman.[54] The teaching is similar to Catholicism. Judaism considers the fetus part of the pregnant woman. Most Islamic scholars believe the fetus becomes a person when ensoulment occurs. The fetus' status differs from Catholic and Jewish teachings on when the fetus becomes a person. The fetus' life must be respected once it becomes a person.[55] All three religions agree on this teaching.

Fetuses have some rights in Islam. The inheritors of a fetus must be paid a monetary ransom called the "ghorrah" if a fetus is unjustly aborted. The ransom is one-tenth of that required for killing an adult.[56] Some scholars put the ransom at one-twentieth of that of an adult.[57] The ransom applies to a fetus under four months of age or a dead fetus older than four months. If the fetus is over four months and willingly aborted

and born alive, the full adult ransom is paid.[58] Additional judicial punishment is permitted besides the ransom. The Shafi'i and Hanafi schools include any gestational tissue a pregnant woman may pass as qualifying under the above laws.[59] Fetuses also have inheritance rights once they are born if a parent dies during the antepartum period.[60]

Because the fetus has the above rights in Islam, the fetus also has a right to life. According to Hassan Hathout "this sanctity of life cannot be sacrificed except on the grounds of the Islamic rule of 'conflict of interest."[61] The rule is similar to the concept of "the unjust aggressor."[62] The pregnant woman is morally obligated to have a cesarean section as the concept of the unjust aggressor does not apply in this situation. The fetus is not threatening the pregnant woman's life and is over 120 days, giving it a right to life.

5.2d Summary

All of the three religions are consistent in believing that all life is sacred, has dignity and value regardless of its quality, and is to be respected. All three agree that God is the author of life who determines when life begins and ends. The three religions agree these principles must be taken into account with decisions affecting the fetus. However, the three religions differ as to the status of the fetus. Catholicism believes the fetus should be treated as a person with rights from the moment of conception. Islam believes the fetus becomes a person at 120 days with a right to life. Judaism believes that the fetus does not become a person until birth – when the head is delivered or the greater part of the body is delivered if breech.

Based on the status of the fetus in both Catholicism and Islam, the term fetus is considered a person with a right to life. The fetus' status alone morally obligates the pregnant woman to undergo the cesarean section for the benefit of the fetus when her life

is not endangered. The fetus is not a person with the same rights as the pregnant woman in Judaism. Therefore, she is not morally obligated to undergo the cesarean section based on this alone. But sanctity and respect for life should also be considered in the decision.

5.3 Autonomy, Informed Consent, and Stewardship

Autonomy is not necessarily a principle used to frame and justify different religious perspectives. Rather, individuals are encouraged to be good stewards of the gift of their life and body.[63] The concept of stewardship shapes and guides individuals' decisions. However, some authors do discuss religious views on autonomy to compare them to the philosophical principle of respect for autonomy and legal liberty rights. Autonomy's role in informed consent of patients from religious perspectives is also examined by various writers.

5.3a Catholic

Catholicism teaches the concept of stewardship. Stewardship is based on the teaching that God has provided resources here on earth that we are called to care for and develop.[64] We are all stewards over God's gifts to us. Included in these gifts are our own lives and the lives of others. One is morally obligated to care for one's own health.[65] The pregnant woman also has a special responsibility of stewardship towards her fetus. The fetus is totally dependent on the pregnant woman for its proper growth, development, and survival until it is born, with all of the pregnant woman's actions and decisions affecting the fetus. Because of the total dependence of the fetus on the pregnant woman, stewardship morally obligates the pregnant woman to do what is best for the developing fetus, especially when the pregnant woman's health and life are not threatened or

endangered. Stewardship morally obligates the pregnant woman to undergo a cesarean section for the benefit of her fetus.

The Catholic Church's teachings on stewardship and the status of the fetus guide the pregnant woman's autonomous acts and decisions. The fetus' status is the same as the pregnant woman's. The pregnant woman must take into consideration the rights of the fetus as a person in Catholicism. Secular ethical and legal views that the rights of one already born are more important than the rights of one who has yet to be born are not found in Catholicism.

Autonomy in Catholicism is not absolute. Msgr. Javier Lozano Barragan believes each person has freedom and responsibility, which includes respecting the freedom of others.[66] He states "the principle of autonomy means the freedom of the moral agent, which in turn is said to indicate that an action is good if it respects the freedom of the moral agent and of other people."[67] The Church, in Vatican II, Gaudium et Spes, discussed earthly autonomy. According to Alfonso Llano:

> if we take the autonomy of earthly realities to mean that created things, and societies also, have their own laws and values which are to be gradually discovered, utilized and ordered by us, then it is perfectly proper to claim autonomy as not only demanded by people today but as in close harmony with the will of the creator…If however, the autonomy of earthly realities is taken to mean that created things are not dependent on God and that we can use them without reference to their creator, then anyone who acknowledges God realizes the falsity of such opinions.[68]

Autonomy does not mean one can act on conscience alone and ignore Church teachings and documents. Llano's opinion is:

> the Church teaches expressly that autonomy must be moderated through the recognition of the existence of God and the authority of his Church. Autonomy does not consist in following one's conscience alone, but rather it is most appropriately found in the ability to form one's own moral

> assessments and judgments in the light of the teaching of other sciences, persons, and the Church.[69]

He also believes "thinking, consulting, and seeking guidance are a part of autonomy and that it is not absolute."[70] Pierre DuMaine and Gerald Coleman have a similar opinion:

> when autonomy is absolutized, very little thought is given to the values that ought to inform and guide its use. Given such a vacuum, the sheer fact that a choice is the individual's tend to be viewed as the sole right-making characteristic of the choice.[71]

The pregnant woman should consult and seek guidance from scripture, magisterial teachings, her priest, and her physicians before making decisions. Autonomy in Catholicism is not isolated as to what is best for the individual. Rather, the Catholic view of autonomy requires the pregnant woman to be guided by the Church's teachings on the status of the fetus and stewardship when making decisions concerning medical care and treatment for both her and her fetus. The fetus is to be treated as a person with rights equal to the pregnant woman and cannot be directly killed. Therefore, the pregnant woman is morally obligated to undergo a cesarean section to save the fetus' life or prevent serious injury to the fetus when her life is not endangered by the procedure.

However, the pregnant woman must consent to the cesarean section. The Ethical and Religious Directives for Catholic Health Care Services state:

> 26. The free and informed consent of the person or the person's surrogate is required for medical treatments and procedures.
>
> 27. Free and informed consent requires that the person or the person's surrogate receive all reasonable information about the essential nature of the proposed treatment and its benefits, its risks, side-effects, consequences, and costs, and any reasonable and morally legitimate alternatives, including no treatment at all.
>
> 28. Each person or the person's surrogate should have access to medical and moral information and counseling so as to be able to form his or her conscience. The free and informed health care decisions of the person or

> the person's surrogate is to be followed so long as it does not contradict Catholic principles.[72]

The pregnant woman's moral obligation to undergo the cesarean section for the fetus' benefit includes the moral obligation to consent to the cesarean section.

In the 1975 edition of the Ethical and Religious Directives, Directive #15 was "Cesarean section for the removal of a viable fetus is permitted, even with risk to the life of the mother when necessary for successful delivery. It is likewise permitted even with risk for the child, when necessary for the safety of the mother."[73] However, this particular directive was not included in the current fourth edition approved in 2001 by the United States Conference of Catholic Bishops. Directive #47 does say that "operations, treatments, and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman are permitted when they cannot be safely postponed until the unborn child is viable, even if they will result in the death of the unborn child."[74] The directive does not address the situation of performing a procedure or treatment for the benefit of a viable fetus. But, Directive #49 states "for a proportionate reason, labor may be induced after the fetus is viable."[75] If induction of a vaginal delivery is permitted when medically necessary, then a cesarean section should also be permitted when medically necessary for proportionate reason after viability. Induction may fail and result in a cesarean section being necessary for delivery. Proportionate reason includes situations where the benefit to the fetus is greater than the risk to the pregnant woman from delivery.

Carol Tauer points out that "the Directives clearly permit Cesarean sections when necessary…But even though they sometimes allow one person to endanger herself for the sake of another, they require consent 'in all cases."[76] She believes the Ethical and

Religious Directives support the ethical theory that one individual cannot be forced to be at risk for harm solely to benefit another.[77] The same concept is found in Jewish teaching. The Catholic Church's teachings on the status of the fetus, stewardship, and autonomy do not override the need for informed consent from the pregnant woman.

Directive #28 does seem to leave some room for debate as it states a patient's or surrogate's free and informed decision "is to be followed so long as it does not contradict Catholic principles."[78] One can argue that refusing a cesarean section that benefits the fetus could contradict Catholic principles. But nowhere in the Directives is the use of force or coercion advocated if needed to perform the cesarean section. Directive #23 states that "the inherent dignity of the human person must be respected and protected."[79] Forcing or coercing treatment does not respect the dignity of the patient. Directive #23 applies to all patients. Similar to Tauer, concerning a pregnant woman undergoing a procedure for the fetus' benefit, Sgreccia's opinion is:

> from an ethical point of view, it appears that the mother's consent is necessary and must therefore be requested. On the other hand, in relation to the urgency and foreseeable efficiency of the intervention itself, such consent from the mother is right, so if she refuses it she is committing an illicit act and is responsible for the consequences.[80]

There is one situation, when using a two-patient model, where Tauer believes the informed consent of the pregnant woman is not necessary. She states "when near-certain harm to the fetus is coupled with probable benefit to the woman, the institution may ethically override her right to refusal of a cesarean."[81] When refusing the cesarean section and delivering vaginally will harm the fetus, along with putting the pregnant woman's health at greater risk, consent is not needed. An example is complete placenta previa in which both lives are at risk due to bleeding with a vaginal delivery. However, she

acknowledges doing the surgery without the pregnant woman's consent leaves the institution open to legal actions. Other methods of achieving the same results are preferred from an ethical viewpoint.[82] Tauer recommends seeking a court order to protect the institution from legal actions. She also recommends establishing institutional policies that outline these types of situations.[83]

Tauer's exception does not apply when the cesarean section places the pregnant woman at greater risk for harm.[84] A cesarean section performed solely for the fetus' benefit does not meet Tauer's conditions as there is no benefit to the pregnant woman's health. Tauer also believes the exception is not applicable under a one-patient model as the pregnant woman cannot be forced to undergo a medical procedure she refuses.[85] The exception only applies to a two-patient model. Many Catholic hospitals use a two-patient model for pregnancy.[86]

Tauer does not actually discuss what degree of force is to be used to fulfill her exception to requiring informed consent from the pregnant woman. As discussed in chapter two, there is no guarantee the courts will order the pregnant woman to have the cesarean section. Even if the court orders the cesarean section, force may be required in cases where the pregnant woman still refuses to undergo the surgery.

5.3b Jewish

Differences that may exist between the three branches of Judaism on ethical issues are due to the sources of authority for each branch. The sources of authority include Jewish law known as halakhah, personal autonomy, reason, experience, and tradition. According to Deena Davis, who writes from a Reform Judaism perspective, Orthodox Jews look solely to halakhah, Jewish law, which "is the unchanging will of

God," while Conservative Jews also look to halakhah, but may use other sources along with it, as Conservatives do not see halakhah as static and unchanging.[87] Reform Jews look to, according to Davis:

> personal autonomy, justice, and individual rights, grounded in divine warrant. Reformist identify primarily with the prophetic rather than the legal tradition in Judaism and they emphasize universal ethical principles and a social justice critique of contemporary society.[88]

Halakhah is also increasingly considered by some Reformed Jews as a source of authority or guidance.

According to the Encyclopedia of Jewish Medical Ethics, the concept of informed consent is not found in halakhah since it is a relatively new term.[89] Also, the Encyclopedia states the "fundamental values upon which the concepts and parameters of informed consent are formulated nowadays are not in full accord" with halakhah.[90] The fundamental values are autonomy and ownership of one's body.[91] Benjamin Freedman, an Orthodox author, articulates some Orthodox writers' views on informed consent. Freedman points out "with the single substantive exception of consent to hazardous, nonvalidated medical and surgical treatment (often misleadingly termed 'experimentation'…), the doctrine of informed consent is mentioned only so that it may be dismissed as of any Jewish relevance."[92] The halakhic duty to seek healing when sick and the physician's duty to heal nullifies the values underlying informed consent for these authors.[93] Freedman presents their opinion that "according to halakhah, the mode of treatment is frequently not established according to the will of the patient and his consent, but rather according to the objective situation" and is based on the teaching "do not stand idly by your neighbor's blood."[94]

Freedman disagrees with these views on informed consent. He believes they are superficial. He sees informed consent as a relationship between the physician and the patient that involves life decisions for the patient.[95] Informed consent for Freedman is not just the moment of decision-making for the patient, but rather the process of educating and negotiating with patients.[96] The benefits are mutual respect, improved communication, and promoting and protecting autonomy.[97] Freedman believes this definition of informed consent is in keeping with Jewish teaching that one is a steward of his or her health. Individuals need to obtain all the necessary information, options, and ask questions to best care for the gift of their bodies. The process of informed consent allows one to do this.[98]

Autonomy, in traditional Jewish teaching, is limited to morally indifferent actions for individuals, but is highly valued and demanded concerning respect for others.[99] Autonomy, like informed consent, is also guided by halakhah which requires Jewish people to seek healing and, according to the Encyclopedia, "preserve one's health and life, to avoid harming others, and to do good for others."[100] Traditionally, this concept of stewardship guides the acts of Jewish individuals. According to Yosef Lamdan, the traditional Jewish model of decision-making:

> requires the patient to make a free choice to waive much of his decision-making power to others, in line with his voluntary acceptance of the Torah and the Halachah. In effect, observant Jews make a conscious choice to limit the scope of their autonomy in medical matters to rather narrow areas, which can be deemed 'neutral,' both morally and religiously.[101]

However, the degree to which individual autonomy is shaped and guided by halakhic teaching can vary between the three branches of Judaism. Orthodox Jews believe halakhah is the guiding authority and autonomy is not considered if it conflicts

with halakhic teaching. Reform Jews see autonomy as a primary guiding principle and may or may not give halakhah some consideration. If the two conflict, autonomy will be primary for some Reform Jews. Conservative Jews believe halakhah is primary, but do allow for the autonomy of the individual to be considered.[102]

Likewise, there is variation among writers and Rabbis of the different branches as to the principle of ownership of one's body. The traditional Jewish teaching is one's body is a gift from God. The individual has no ownership rights, but instead is a caretaker of one's body and is required to seek health care and healing when sick.[103] The more liberal view is one does have some ownership rights over one's body.[104] If a woman believes she has some ownership rights over her body, then she believes she can make autonomous decisions concerning her health care. But if she is simply a caretaker of her body, she is required to undergo all recommended medical treatment to restore health, unless the treatment is experimental or will likely cause her more harm than good.

Only for Reform Jews are the autonomy of the pregnant woman and ownership of her body considered primary guiding principles. Reform Judaism, according to Alvin Reines, a Reform author, believes that each individual is the ultimate owner of her body. Other individuals cannot exercise their authority over another individual. He states "according to Reform Judaism, the moral rights of a person to exercise authority stops where another person's autonomy begins."[105] The Reform Jewish pregnant woman will decide whether she wishes to have the cesarean section based on these and other ethical principles. However, some Reform Rabbis believe halakhah should also be considered as a source of guidance to Reform Jews in decision-making.[106] Informed consent is also a primary consideration for some Reform Jews.

Halakhah provides the primary guiding ethical principles for Orthodox and Conservative Jews. One of the guiding principles is stewardship, the obligation to care for one's health. Jewish doctors likewise have a halakhic obligation to heal. David Feldman, a Conservative author, writes "to Maimonides, this is the biblical source of the mandate to heal: to come to the aid of one who has lost his health and needs restoration."[107] The obligation is based on the mitzvah of restoring lost objects in Deuteronomy 22:2 – "if you chance upon an object lost by your brother, you must restore it to him."[108] Feldman sees the preservation of life and health as a mitzvah of the first rank.[109]

If one looks solely to this particular halakhic teaching, one can say the pregnant woman is the incubator and caretaker of the fetus until it is born. Therefore, she is responsible for the fetus' health and well-being. The pregnant woman has a moral obligation to undergo whatever treatment is recommended by her doctor to benefit the fetus provided it does not endanger her health or is not considered experimental. The pregnant woman is morally obligated to have the cesarean section.

5.3c Islamic

Like Catholic and Jewish moral theories, Islamic moral theories guide an individual's autonomy. B. Larijani, et al., write that "from the Islamic viewpoint, people are autonomous in the decision-making process if they are able to understand and make intelligent decisions for themselves which are intentional and voluntary."[110] Islamic culture emphasizes altruism and benevolence to others.[111] However, Islam does not allow one to act as one wants, but instead one must act within certain rules. Individuals should also act with knowledge. Islam believes God gave man knowledge of good and bad,

along with freedom, one of the highest of human values, at birth. There is also an obligation to follow, according to Sahin Aksoy and Abdurrahman Elmali, a "prevailing opinion or a fairly certain presumption based on 'knowledge."[112] The autonomy of the pregnant woman is shaped by her duty to follow Islamic law and teaching. Acting with knowledge morally obligates Islamic pregnant women to learn the law and teachings that guide her decisions concerning her and her fetus' medical care and treatment during pregnancy.

The concept of stewardship is also part of Islamic law and teaching. Humans are trustees of their bodies.[113] Stewardship includes nonmaleficence and beneficence. The principle of nonmaleficence, not doing harm, is found in the Quran and Hadith. Islam does not allow one to cause harm to one's own health and life. Islam also does not allow one to harm others, even if they have harmed you.[114] Beneficence is intimately linked to nonmaleficence in Islamic teaching. The Quran speaks of rewards for doing good.[115] Beneficence, according to Aksoy and Elmali, "is so dominant to other principles that we can say the principle of beneficence is the starting point in all kinds of human relationships."[116] The duties of nonmaleficence and beneficence in Islam also shape the pregnant woman's autonomy and guide her decisions regarding her and her fetus' medical care and treatment during pregnancy. The pregnant woman is not allowed to cause harm to herself or her fetus and should do good for her fetus. These teachings will morally obligate the pregnant woman to have a cesarean section for her fetus' benefit when her life is not endangered.

Physicians, in Islam, are required to be just and skillful. They should avoid causing harm to patients in this world and the hereafter.[117] The physician's duty is to try

to heal the patient.[118] Stewardship is required of the physician also. Physicians are given a place of respect in Islam because of their knowledge, scientific expertise, history, and the fact that they are regarded as instruments of divine mercy.[119] According to Farhat Moazam:

> the 'doctor sahib' (sahib has an Arab root, meaning 'lord') remains the authority in all matters relating to the disease and medical interventions. She is often symbolically inducted into the family and is expected to direct rather than facilitate the medical management. In the final analysis, however, God, not man, remains the final controller of life and the timing of death.[120]

The teachings concerning the status and role of the physician in Islam also guides the pregnant woman's decision-making concerning medical care and treatment for her and her fetus. The physician, not the patient, makes decisions and directs the medical care of the pregnant woman and her fetus. The physician's duty is to heal and not cause harm to the pregnant woman and her fetus. The physician is morally obligated to perform the cesarean section for the fetus' benefit when the harm to the pregnant woman is minimal and the benefit to the fetus is great.

5.3d Summary

The pregnant woman's autonomy is guided and shaped by the moral theories of the Roman Catholic Church, Judaism, and Islam. Catholicism teaches that the pregnant woman's autonomous decisions should be informed by the Church's beliefs that the fetus should be treated as a person with rights from the moment of conception. But her informed consent is needed for any medical treatment or procedure. Islam is similar, requiring one's acts and decisions to be guided by Islamic law and knowledge. Islam also requires the pregnant woman's physician to direct the pregnant woman's medical care

and decisions. The Islamic physician's obligation to heal and not cause harm directs the decisions for the pregnant woman and her fetus who at term is a person with rights. Orthodox Judaism requires the pregnant woman to follow halakhah and seek healing. The physician is also required to heal, the same as in Islam. By contrast, Conservative Judaism allows for some autonomy to be considered. For many Reformed Jews, autonomy is primary. All three religions teach the concept of stewardship of one's body and of the fetus. For many religious authors, stewardship rather than autonomy is used to frame individual moral obligation.

5.4 Abortion

Catholic, Jewish, and Islamic moral theology all have different teachings concerning the permissibility of abortion. These differences are a result of the previously discussed views on the status of the fetus.

5.4a Catholic

Direct abortion, the direct killing of an innocent fetus, is not permitted in Catholic moral theology. The Principle of Double Effect is the method used to determine whether an abortion is direct and not permissible or indirect and permissible. The Church does not allow the fetus to be viewed as an unjust aggressor of the pregnant woman.[121] The teaching is true regardless of whether the fetus is a threat to the pregnant woman's health or life and is derived from the Church's teaching on direct abortion. While Charles Curran believes Catholic theology and natural law should recognize a broader scope on the permissibility of abortion than the magisterium does, he articulates the magisterium's position. Curran states "in the question of abortion the hierarchical magisterium in the

Roman Catholic Church taught that the fetus cannot be considered as an unjust aggressor since the fetus in the womb is just doing what is necessary to preserve its own life – hence the mother cannot kill the fetus in self-defense."[122]

Although the 2001 Fourth Edition of the Ethical and Religious Directives do not specifically mention the Principle of Double Effect, a number of directives do employ proportionate reasoning. Proportionate reasoning is used in Directive #30 which pertains to living organ donors and Directive #33 which refers to the use of therapeutic procedures that can cause harm or undesirable side-effects.[123] Concerning pregnancy, as stated previously, Directives #47 and #49 invoke proportionate reasoning, along with Directives #50 and #51.[124] Directive #50 states:

> prenatal diagnosis is permitted when the procedure does not threaten the life or physical integrity of the unborn child or the mother and does not subject them to disproportionate risks; when the diagnosis can provide information to guide preventative care for the mother or pre- or postnatal care for the child; and when the parents, or at least the mother, give free and informed consent. Prenatal diagnosis is not permitted when undertaken with the intention of aborting an unborn child with a serious defect.[125]

Directive #51 states:

> Nontherapeutic experiments on a living embryo or fetus are not permitted, even with the consent of the parents. Therapeutic experiments are permitted for a proportionate reason with the free and informed consent of the parents or, if the father cannot be contacted, at least of the mother. Medical research that will not harm the life or physical integrity of an unborn child is permitted with parental consent.[126]

Directive #33 states "therapeutic procedures that are likely to cause harm or undesirable side-effects can be justified only by proportional benefit to the patient."[127] The question raised here is who is the patient, the fetus or the pregnant woman, when determining harm. Both are equal persons with the same rights according to Catholicism.

Using the two-patient model here makes it harder to weigh harms and benefits to both. In this case, the benefits of the cesarean section are for the fetus, with minimal harm to the pregnant woman. But there are no direct benefits to the pregnant woman's health. Viewing the pregnant woman and fetus as one patient will allow a better assessment of risks and harms as instructed in this directive.

The intentional killing of an innocent life is not permitted according to Catholic moral theology.[128] Only if a pregnant woman refuses a cesarean section with the explicit intent of causing the death of her fetus is her refusal definitely morally wrong. But in most cases, she refuses treatment for other reasons, as discussed in chapter one, and believes the fetus will be fine without the surgery. Usually the pregnant woman's only intent is to avoid the cesarean section, not to harm her fetus.

Death or severe injury to the fetus outweighs the minimal harm or risk to the pregnant woman in this situation. Her life is not at risk by undergoing the cesarean section. Nor is she at risk for serious harm from the cesarean section. Since the fetus and pregnant woman's lives have equal value, the harm to the fetus far outweighs the harm the pregnant woman is trying to avoid by not having the cesarean section when proportionate reasoning is applied. Proportionate reasoning morally obligates the pregnant woman to undergo the cesarean section for her fetus' benefit.

The Principle of Double Effect is applied here to determine whether having the cesarean section itself is morally permissible. The principle, according to David Kelly, "purports to answer the following question: Is it right to perform an action from which two or more effects result, some of which are good and may rightly be intended and some of which are bad and may not rightly be intended."[129] There are four conditions to the

principle. All four must be met for the act to be morally right.[130] The four conditions are, according to Kelly:

> (1) the act-in-itself must not be morally wrong. (2) The bad effect must not cause the good effect. (3) The agent must not intend the bad effect as an end to be sought. (4) The bad effect must not outweigh the good effect.[131]

Taking the situation of a pregnant woman undergoing a cesarean section recommended to prevent death or serious injury to a term fetus when her life is not endangered through the four conditions of the principle of double effect will determine if this is a morally permissible or right act. The act itself, the cesarean section, is in and of itself not morally wrong, as Kelly states, "regardless of circumstances, situations, or consequences."[132] The act meets the first condition of the principle of double effect.

The second condition of the principle of double effect is also met. The causal chain from act to effects, in general, can lead to one of three possibilities – the act causes the good effect which then results in the bad effect; the act causes the good and bad effects simultaneously; or the act causes the bad effect which leads to the good effect.[133] The first two are permissible. The third is not. The good effect is preventing severe harm or death to the fetus. The bad effect is the minimal risks or side-effect to the pregnant woman from undergoing the cesarean section. The pregnant woman undergoing the cesarean section causes both the good and bad effects to occur simultaneously. Therefore, the second condition is met.

The third condition depends on the intention of the pregnant woman. If she does not intend death or serious injury to the fetus, or harm or risk to herself, according to Kelly, "as an end to be sought," then undergoing the cesarean section meets the third condition.[134] The fourth condition states, according to Kelly, "the bad effect must not

outweigh the good effect."[135] As discussed previously, preventing serious harm or death to the fetus outweighs any potential harm or side-effects to the pregnant woman. Therefore, the fourth condition is met. The pregnant woman undergoing the cesarean section is a morally permissible act per double effect.

Since the cesarean section in this case is permissible and having the cesarean section to benefit the fetus outweighs the risk to the pregnant woman using proportionality, the pregnant woman is morally obligated to undergo the cesarean section.

5.4b Jewish

All branches of Judaism teach that abortion is permissible when the pregnant woman's life and health are endangered. Jewish teaching differs from Catholicism where only indirect abortions are morally permissible even when the pregnant woman's life is threatened. Since the fetus, according to Judaism, is not a person, saving the pregnant woman's life takes precedence. In fact, having the abortion is mandatory, as refusing an abortion that would prevent the pregnant woman's death is considered suicide, which is not permissible in Judaism.[136]

Maimonides based permissibility for abortion when the pregnant woman's life is endangered on the pursuer principle. The principle says that if a person is pursued by another who intends to kill her, then the pursuer must be stopped, even if this means killing the pursuer. Killing the pursuer is permitted only if there is no other way to preserve one's life.[137] The fetus can be seen as a pursuer or aggressor who is endangering the life of the pregnant woman. Therefore, abortion is permissible to save the life of the pregnant woman.[138] The principle is similar to the Islamic concept of the fetus as the unjust aggressor. Both differ from Catholicism which teaches that the fetus cannot be

viewed as an unjust aggressor.[139] However, these teachings do not apply in this situation as the fetus' life is in danger, not the pregnant woman's. The fetus is not considered an aggressor or pursuer in this situation.

Feticide is not considered homicide in Jewish law. The law is based on Exodus 21:22.[140] The verse states "when men fight, and one of them pushes a pregnant woman and a miscarriage results, but no other damage ensues, the one responsible shall be fined according as the woman's husband may extract from him, the payment to be based on reckoning."[141] Only monetary damages are required if one strikes a pregnant woman and causes the fetus to abort. The punishment is not considered a capital crime and is consistent with the teaching that the fetus is not a full person.[142] The teaching also does not morally obligate the pregnant woman to have a cesarean section when her fetus' life is endangered.

Judaism has two sets of laws that are from divine revelation. Those from the Sinai covenant apply to Jews. The others are for all non-Jewish people and are called "the Seven Commands of the Sons of Noah."[143] Louis Newman, a Reform author, writes "all Jewish authorities agree that these Noahide laws are the moral norms God expects all human beings to observe…it would appear to offer a basis for a Jewish view of norms applicable in a pluralistic society."[144] The Noahide Law found in Genesis teaches that feticide is a capital crime for non-Jewish people.[145] The Noahide penalty for abortion is death for non-Jews.[146] According to Feldman, this is based on Genesis 9:6 which states "he who sheds the blood of man, through man shall his blood be shed."[147] The passage has been interpreted in the Talmud as "man, in man" and "refers to the fetus in its mother's womb."[148] However, Feldman believes there is an 18th century responsum

which states that the fetus' status is the same – it is not considered a person in Noahide law.[149] Newman theorizes the reason for the stricter law may be that the rabbis of the time were trying to instill in non-Jews the teaching that all life is sacred and should be respected and preserved. The law leads to a strong pro-life position in society.[150] If one looks at these teachings and the distinction between laws for Jews and non-Jews, unlike the Jewish woman, the non-Jewish pregnant woman is morally obligated to preserve the life of her fetus in all cases.

Arakhin 7 (a)-(b) concerns a pregnant woman who is to be executed. The passage teaches that the execution should not be delayed, as doing so would prolong the pregnant woman's mental anguish.[151] The passage states, according to Davis, "one should strike the woman against the womb so that the child may die first, to avoid being disgraced."[152] She believes "this ruling in Arakhin suggests a general principle that a fetus may be aborted to avoid mental anguish or disgrace to the mother."[153] She also believes "the decisive principle here is that the woman's pain comes first…The mother's pain is decisive even when her suffering appears rather trivial."[154] If this teaching and Davis' conclusions for the permissibility of abortion are applied to the pregnant woman who is advised to have a cesarean section to save the life of or prevent serious harm to her fetus, she can morally refuse the cesarean section if having it causes her mental pain or anguish, no matter how trivial this may seem to others. The pregnant woman's needs come first over those of the fetus based on this teaching. However, not all authors agree with the idea of abortion for mental anguish.

Feldman believes that the permissibility of abortion in Judaism is considered based on maternal, not fetal, indications.[155] The reason is the future of the fetus is

unknown and there are no guarantees as to what physical problems the fetus will or will not have when it is born.[156] David Bleich, an Orthodox author, states that according to halakhah, the individual's status as a person is not affected by physical or mental abnormalities.[157] Abortion is permitted only because of the mental anguish to the pregnant woman caused by the possibility of a child with physical or mental problems.[158] The pregnant woman can refuse a cesarean section based on this if having a child with physical or mental problems causes her mental anguish.

Even though a fetus is not a full human person, according to Davis, "David Bleich speaks for the tradition when he says, 'Judaism regards all forms of life as sacred…fetal life is regarded as precious and may not be destroyed wantonly."[159] For Bleich, this does not depend on the fetus being a person.[160] Many conservative thinking Jewish writers, such as Bleich, believe abortion is only permitted to save the life of the pregnant woman. Aaron Mackler points out other authors with this view:

> For authorities such as Ezekiel Landau (eighteenth century) and Hayim Soloveitchik (nineteenth century), however, the status of the fetus is virtually equal to that of the mother. Abortion is permitted only to save her life, justified by the pursuer argument in conjunction with the slightly lesser status of the fetus.[161]

Bleich believes that abortion is permitted only when the pregnant woman's life is in danger. The teachings he bases this on are the fetus receives a soul at the moment of conception; the Sabbath is set aside to save the life of a fetus; and the body is not one's own but owned by God for which one is obliged to care. According to Bleich, "the fetus is not merely an appendage to the mother, but a being in its own right."[162] He also believes:

> The net effect of the ban against feticide, on whatever grounds it is based, is to endow the unborn fetus with a 'right to life.' Whether an unborn child

> is a 'person in the full sense' or simply a 'fetus' is irrelevant insofar as the fetus' title to life is concerned. It is only when respect for the fetal right to life poses a threat to the mother that a question arises.[163]

If one agrees with Bleich and other conservative thinking Jewish writers' views on the status of the fetus, the fetus' right to life, and the prohibition of feticide unless the pregnant woman's life is threatened, then an argument can be made that the pregnant woman will be morally obligated to undergo the cesarean section in this case. Respecting the fetus' right to life is not posing a threat to the pregnant woman's life. If the fetus' life is believed to be sacred and precious, then acting for the benefit of the fetus by having the cesarean section is required ethically.

5.4c Islamic

According to Bakar, "Muslim jurists classify all human acts into five categories, namely (1) the obligatory (wajib), (2) the recommended (mandub), (3) the allowable or the indifferent (mubah), (4) the blameworthy or the discouraged (makruh), and (5) the forbidden (haram).[164] Since Islam lacks an organized church and ordained clergy, qualified scholars of religious law determine into which one of the above five categories an act falls.[165]

Islamic teachings on the status of the fetus form the basis of the permissibility of abortion for Islam. Abortion, at the most liberal level, has been placed by the jurists in the category of the allowable or the indifferent.[166] However, some conservative jurists place abortion in the category of the forbidden. Whether abortion is permissible in Islam is not a question of the rights of the pregnant woman or the fetus but instead a question of possible physical harm to the pregnant woman and how it affects her family.[167] Possible emotional and psychological harm to the pregnant woman as a result of her pregnancy

may also be considered in some cases. The teaching is similar to Jewish views on abortion. As stated previously, the pregnant woman's physician plays a central role in this determination.[168]

Most Sunni and Shi'ite schools prohibit abortion after 120 days since the fetus is considered a person at that point. Therisa Rogers states "after 120 days, however, a fetus is a Muslim person and should be treated accordingly…'Treated accordingly' means buried in a Muslim cemetery and avenged in the case of death."[169] Abortion is permitted after 120 days when the pregnant woman's life is threatened.[170] Moazam believes "this is based on the juristic principles that 'the mother is the origin or root, whereas the embryo is a branch' and that 'a greater evil (in this case the death of the mother) should be warded off by the lesser evil (the death of the fetus)."[171] The fetus is sacrificed in favor of the pregnant woman as she is fully alive and the fetus is not before birth.[172] The Al-Fatewah commentaries, a secondary source of Islamic law, according to Aryeh Spero, state that "she is established in life with duties and responsibilities while the fetus has no responsibilities or obligations to fulfill."[173]

A few scholars permit abortion if the physician believes the fetus will be severely deformed or unlikely to live after it is born.[174] Abortion is also permitted if the pregnancy will interfere with a child who is currently breast feeding and the father cannot afford a wet nurse.[175] Ibn Hazam, a Muslim scholar, stated centuries ago that a fetus over 120 days, according to Rogers, "is a live person - he judges it to be essential that such a fetus be saved by cesarean section if the mother is dead, to avoid burying a live fetus with a dead mother, which would be wrong."[176] The teaching is similar to that of Maimonides. All of the above morally obligates the pregnant woman to have a cesarean section for the

benefit of her fetus when her life is not endangered and the fetus is over 120 days of gestation.

In Islam, Najma Moosa states, "children have an inalienable (first) right to life."[177] God is the one who gives and takes away life to all, so parents cannot take or interfere with the life of a child. God has entrusted parents with their children's lives which they must protect or answer to God when they do not.[178] Rogers believes the Quran verse 6:140 specifically forbids the killing of children. The verse states "they are lost indeed who kill their children foolishly without knowledge, and forbid what Allah has given to them, forging a lie against Allah: they have indeed gone astray, and they are not the followers of the right course."[179] She also believes the Quran instructs parents not to kill their children because of poverty in verse 6:151 – "…and do not slay your children for (fear of) poverty – We provide for you and for them – and do not draw nigh to indecencies, those of them which are apparent and those which are concealed, and do not kill the soul which Allah has made sacred except for the requirement of justice; this he has enjoined you with that you may understand."[180] The Quran also considers killing female children because of their sex as evil.[181] The abortion of a fetus over 120 days is very close to this grave sin of killing a child.[182] These teachings also morally obligate a pregnant woman to undergo a cesarean section that would prevent the death of her term fetus, as letting the term fetus die could be considered close to the grave sin in Islam of killing a child.

5.4d Summary

Teachings on abortion differ between the three religions. Direct abortion, as determined by the Principle of Double Effect, is not permitted in Catholicism, even if the

pregnant woman's life is endangered by the pregnancy. Abortion is not permitted in Islam after 120 days unless the pregnant woman's life is endangered. Similarly, all branches of Judaism permit abortion if the pregnant woman's life is endangered. These teachings form a major difference between Catholic, Jewish and Islamic beliefs concerning abortion. Catholicism does not recognize the fetus as an aggressor or pursuer, whereas Judaism and Islam do. The life of the pregnant woman, if threatened, is to be valued in Judaism and Islam over the life of the fetus. In Catholicism, they are seen as equal. However, differences exist between the three branches of Judaism as to the permissibility of abortion for other reasons.

The fetus as an aggressor or pursuer does not apply to the pregnant woman having a cesarean section to benefit her term fetus when her life is not being endangered by the pregnancy in any way. Catholicism and Islam will morally require the pregnant woman to undergo the cesarean section. Whether the pregnant woman is morally required to undergo the cesarean section depends on which branch of Judaism she follows and which teachings and sources of authority she looks to for guidance.

5.5 Other Religious Teachings

Some other moral teachings in Catholicism and Judaism can be considered in situations of maternal-fetal conflict. These include love of neighbor and morally ordinary and extraordinary treatment.

5.5a Love of Neighbor

The pregnant woman's moral obligation to her fetus in this situation can also be viewed from the New Testament teaching of Jesus to love one's neighbor as oneself.

Nazeem M.I. Goolam writes "the fetus, being human, is a neighbor and therefore, his/her life is equal to one's own."[183] Goolam pairs this "with the injunction not to do unto others what you would not do unto yourself."[184] Despite Christine Gudorf expressing views much more accepting of abortion than the magisterium, she nicely articulates a view of love of neighbor that she shares with the magisterium. Gudorf likewise equates love of neighbor with protecting and cherishing human life.[185] Louis Janssens describes love of neighbor as our disposition that directs all of our acts in this world.[186] The fetus, who is to be treated as a person from the moment of conception in Catholicism, is the pregnant woman's neighbor, who she should love and protect as she loves herself.

John T. Noonan Jr.'s application of the teaching of love of neighbor to abortion can also be applied to this situation. He writes:

> The commandment could be put in humanistic as well as theological terms: Do not injure your fellow man without reason. In these terms, once the humanity of the fetus is perceived, abortion is never right except in self-defense. When life must be taken to save life, reason alone cannot say that a mother must prefer a child's life to her own. With this exception, now of great rarity, abortion violates the rational humanistic tenet of the equality of human lives.
>
> For Christians, the commandment to love had received a special imprint that the exemplar proposed of love was the love of the Lord for his disciples. In the light given by this example, self-sacrifice carried to the point of death seemed in the extreme situation not without meaning. In the less extreme cases, preferences for one's own interests to the life of another seemed to express cruelty or selfishness irreconcilable with the demands of love.[187]

Since the pregnant woman is not being asked to sacrifice her life and her only risk is that associated with a routine cesarean section, this seems to be what Noonan refers to as a less extreme case. Love of neighbor in this less extreme case morally obligates the

pregnant woman to have a cesarean section to save the life of or prevent serious injury to her fetus over her own self-interest.

The Hebrew Bible teaches love of neighbor in Leviticus 19:18 - "Love your neighbor as yourself."[188] Even though the fetus is not a full human person with the same rights as the pregnant woman, the fetus can be considered the pregnant woman's neighbor and out of love for her future child she may have a moral obligation to undergo the cesarean section. Also, out of love for her husband and the Jewish community, who can be considered her neighbor, the pregnant woman can have the cesarean section to fulfill the mitzvah of having children. The duty to reproduce falls to the man, not the woman, to fulfill.[189] But the mitzvah cannot be fulfilled without the woman. Jewish couples should at least replace themselves by having a boy and a girl.[190]

A woman is not required to reproduce if doing so threatens her health or life.[191] Bleich believes "the comments of Tosafot, Yevamot 70a and Pesachim 28b, establish the principle that one need not assume the pain and risk of a surgical procedure for purposes of fulfilling even an obligatory mitzvah."[192] He made this comment in reference to a woman's obligation to undergo in-vitro fertilization, not a cesarean section. But in this situation, since the cesarean section does not endanger the pregnant woman's health or life, she may consider having the cesarean section to help fulfill the mitzvah of having children out of love for her husband, her future child, and the Jewish community. The argument may be made that the pregnant woman can have other children in the future if she refuses the cesarean section. But the ability of a woman to get pregnant and have a successful birth is never one hundred percent certain. Also, there is not guarantee that she will not have similar or worse problems with a future pregnancy.

5.5b Morally Ordinary and Extraordinary Treatment

The Catholic Church since the sixteenth century has made a distinction between morally ordinary and extraordinary medical treatment. Benedict Ashley and Kevin O'Rourke define these as "in an ethical perspective, ordinary means to prolong life are 'all medicines, treatments, and operations which offer a reasonable hope of benefit for the patient and which can be obtained or used without excessive expense, pain, or burdens; extraordinary means are all medicines, treatments, and operations which cannot be used or obtained without expense, pain, or other burden."[193] One is obliged to accept morally ordinary treatment. The determination of whether a medical treatment is extraordinary is determined by the individual and includes medical, social, and familial aspects.[194]

As discussed in chapter four, cesarean sections are increasingly being viewed by physicians and pregnant women as an acceptable elective alternative to a planned vaginal delivery. Cesarean sections are no longer performed strictly for medical indications in specific situations. Therefore, cesarean section can be viewed as a medically ordinary treatment. But whether a cesarean section is a morally ordinary or extraordinary treatment is determined by the pregnant woman. Just because a medical treatment or procedure is considered accepted or standard, i.e. ordinary, from a medical perspective does not mean it is ordinary from an ethical perspective.[195] If undergoing the cesarean section is not endangering the pregnant woman's life, a case can be made that it is a morally ordinary treatment when it benefits the pregnant woman's health since having the cesarean section typically does not pose excessive burdens to the pregnant woman. The cesarean section requires only a slightly longer recovery time and the cost is not much different from a vaginal delivery.

However, the cesarean section does not offer any benefit to the pregnant woman in this case. The benefit in this situation is to the fetus. Ultimately, the pregnant woman will have to decide if the benefits to the fetus outweigh the burdens to her from undergoing the cesarean section. Weighing benefits and burdens is easier to do if she views herself and the fetus as one patient and not two. Concerning morally ordinary and extraordinary treatment, determining benefits and burdens is not an objective process based on medical facts but instead is decided by the patient. The Ethical and Religious Directives #32 and 33 reflect this fact. These Directives state:

> 32. While every person is obliged to use ordinary means to preserve his or her health, no person should be obliged to submit to a health care procedure that the person has judged, with a free and informed conscience, not to provide a reasonable hope of benefit without imposing excessive risks and benefits on the patient or excessive expense to family or community.
>
> 33. The well-being of the whole person must be taken into account in deciding about any therapeutic intervention or use of technology. Therapeutic procedures that are likely to cause harm or undesirable side-effects can be justified only by a proportionate benefit to the patient.[196]

If the pregnant woman decides that undergoing the cesarean section imposes excessive risks and burdens to her, she will judge the cesarean section to be morally extraordinary.

5.6 Conclusion

Roman Catholic, Jewish, and Islamic teachings are consistent in their belief that all human life is sacred and has value, dignity, and worth. All believe the pregnant woman's autonomy and the process of informed consent are shaped and guided by religious teachings, including stewardship and the status of the fetus. The three religions are not consistent in their beliefs as to when a fetus becomes a person and their views on the permissibility of abortion.

In the case of a pregnant woman who needs a cesarean section to prevent serious harm or death to her fetus, it can be inferred from the above Catholic moral teachings that the pregnant woman is morally obligated to undergo the cesarean section. The conclusion is primarily based on the Church's teaching that the fetus is to be treated as a person with an equal right to life as the pregnant woman from the moment of conception. The teachings on abortion, love of neighbor, and stewardship also obligate the pregnant woman to act for the benefit of her fetus. These teachings should inform and guide the pregnant woman's autonomous decisions concerning medical care and treatment for her and her fetus. The informed consent of the pregnant woman is always required according to the Ethical and Religious Directives for Catholic Health Care Services.

One can infer that Judaism does not have one consistent position as to whether the pregnant woman is morally obligated to undergo a cesarean section to save the life of or prevent serious harm to her term fetus when her life is not endangered. The role of autonomy, informed consent, ownership of one's body, to what degree the fetus is considered less of a person than the pregnant woman, and what rights the fetus has varies among Jewish writers and the three branches of Judaism. How one sees this issue depends on what value one gives to halakhah, autonomy, and ownership of one's body; how one interprets halakhah and Biblical teaching; and one's view on the status of the fetus as a potential person. The conclusions reached will vary among Jewish pregnant women, depending on which branch of Judaism they belong to and which of the above values and teachings they believe are primary in guiding their decisions. Jewish pregnant women should consult their Rabbis to help them reach an appropriate moral decision in this situation.

One can infer from the above Islamic beliefs that the pregnant woman is morally obligated to undergo a cesarean section for the benefit of her term fetus when doing so does not endanger her life. A fetus over 120 days is a person with a right to life in Islam. The term fetus in this situation is well over 120 days and therefore has a right to life. The pregnant woman's life is not threatened in this situation, so refusing the cesarean section and possibly letting the fetus die is not permissible per Islamic law. A few jurists may possibly allow the pregnant woman to refuse the cesarean section on the basis of her physician deciding that undergoing the cesarean section will cause her emotional and psychological harm. Allowing the fetus to die is close to the severe sin of killing one's child, which the Quran and Hadith prohibit. The life of the fetus is sacred, as Islam teaches that all human life is sacred. God entrusts parents to protect the lives of their children. The pregnant woman is likewise entrusted to protect the life of her term fetus. Her body belongs to God and is not her own. Islam also requires the physician to direct the pregnant woman's medical care and treatment and to not cause harm to the pregnant woman or her fetus. Therefore, based on these Islamic teachings, the pregnant woman is morally obligated to undergo a cesarean section to save the life of her term fetus or prevent serious harm to it when her life is not endangered.

Inconsistencies exist between the normative moral theories of the three religions when applied to a situation of maternal-fetal conflict. Similar to legal, philosophical, and professional medical views, one consistent normative theory or approach to resolving maternal-fetal conflict is not present in Roman Catholic, Jewish, and Islam moral teachings.

In the next chapter, contract is first examined as a possible alternative normative approach for resolving situations of maternal-fetal conflict. Also, the pregnant woman adopting the hermeneutical stance of understanding the maternal-fetal relationship as a covenant relationship to give ethical meaning to her autonomous decision based on the inconsistencies of normative approaches and theories is discussed.

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Chapter 6

Maternal-Fetal Relationship as Covenant

6.1 Introduction

As the previous chapters show, there is no one consistent normative approach or theory for resolving maternal-fetal conflicts. Differences exist within and between legal, philosophical, religious, and professional medical organizations' and physicians' views on this subject. Similarities are found between the pregnant woman's legal liberty rights and the philosophical principles of autonomy and justice. Both support the pregnant woman's right to make decisions concerning medical care and treatment for her and her fetus, even if her decisions are not in her fetus' best interests. These legal rights and philosophical theories are supported by professional medical organizations, such as the American Medical Association, American College of Obstetricians and Gynecologists, England's Royal College of Obstetricians and Gynecologists, and the International Federation of Gynecology and Obstetrics. The AMA and ACOG do give criteria for the rare situation in which exceptions to the above may occur, but do not provide any concrete examples of exceptions. The other organizations do not give any criteria for

exceptions, believing that the pregnant woman's autonomous decisions for her and her fetus will lead to the best outcome.

Contrasting with these views are the legal principle of the state's interest in preserving the potential life of the fetus and the philosophical principles of beneficence and nonmaleficence, along with the pregnant woman's duty to her fetus as her future child. Studies show these principles are supported over the years by varying numbers of physicians. Some physicians also believe the fetus is a separate patient whose individual medical needs must be considered apart from the treatment's effect on the pregnant woman. Viewing the pregnant woman and fetus as separate patients is referred to as a two-patient model as opposed to viewing the pregnant woman and her fetus as one patient. With the one-patient model, decisions concerning medical care and treatment are made based on how they affect both the pregnant woman and fetus. From a religious perspective, the fetus is to be treated as a person with rights from the moment of conception in Catholicism and is a person with rights after 120 days in Islam.

The lack of one agreed upon normative approach or theory for resolving maternal-fetal conflict results in differing beliefs among the parties involved as to what the pregnant woman's moral obligation is toward her fetus. These differing beliefs increase the conflict among the involved parties instead of resolving it. The different legal rights and philosophical and religious views do not provide common normative ground from which the involved parties - the pregnant woman, her physicians, and other health care providers - can discuss a situation of maternal-fetal conflict and reach a treatment plan that all parties are comfortable implementing. The lack of common normative ground leads to suboptimal medical care for the pregnant woman in some cases, as the pregnant

woman avoids hospitals and physicians.[1] The lack of common normative ground also affects the physician-patient relationship, resulting in poor communication and a lack of trust.

In light of these inadequate normative options, this chapter considers a different normative option that all might agree to. In other words, rather than choosing any of the previously discussed inconsistent normative theories or approaches, perhaps there is an alternative distinct normative approach that could provide common ground for all the involved parties in a situation of maternal-fetal conflict. The normative possibility to consider for resolving maternal-fetal conflict is that of contract. In the following discussion, the focus will be on legal contract. But if contract is inadequate from a purely legal perspective in this situation, then it will not fulfill the above described role. Hence, the concept of legal contracts, which are entered into by two or more parties out of self-interest, and the idea of viewing the physician-patient relationship as a contractual relationship based on informed consent and trust are explored. But the idea of a maternal-fetal contract falls short as a legal normative model.

The failure to find a distinct normative category that provides common ground to resolve the situation of maternal-fetal conflict unlike all of the other normative categories discussed leaves the woman to make a choice in a normatively ambivalent situation. That is, there is no agreed upon normative approach or theory to provide common ground for all involved parties in resolving a situation of maternal-fetal conflict. As a result it would appear that the woman must make her autonomous decision within an inadequate normative context. However, the dissertation suggests that more can be accomplished than merely acceding to this unsatisfactory reality by providing depth of meaning to her

decision that transcends the limited range of these normative categories. The advantage of this approach is it builds a bridge between normative and virtue discourse in bioethics. That is, despite the normative ambivalence in which she is forced to make her autonomous decision, she can adopt a hermeneutical stance that provides depth of meaning to her autonomous decision in a manner that enlightens her personal character as a function of virtue ethics. In other words, I propose that the pregnant woman can adopt a hermeneutical stance that gives a depth of ethical meaning to her autonomous decision whether to undergo the cesarean section in a context that is normatively ambivalent. The hermeneutical stance can be based on the Judeo-Christian Biblical covenant relationships between God and humans. The pregnant woman can interpret this developing relationship with her fetus as a covenant relationship that is freely given, reflects the love of the pregnant woman for her fetus, and is based in faithfulness and fidelity. Adopting the hermeneutical stance enlightens the pregnant woman's character and virtue.

6.2 Contract Model

When searching for an alternative common normative approach or theory to use in resolving maternal-fetal conflict, viewing the maternal-fetal relationship as a contractual agreement can be considered. Some believe that a pregnant woman who does not exercise her legal option to abort her pregnancy during the time when doing so is permissible enters a contractual agreement with her fetus to continue the pregnancy.[2] The unwritten or implied contract supposedly obligates the pregnant woman to care for the fetus and do what is needed to result in the live birth of the child. Whether this type of contract between the pregnant woman and her fetus exists and whether it provides a principled normative model warrants careful scrutiny.

6.2a Legal – Definition

According to Black's Law Dictionary, a legal contract is defined as:

> 1. an agreement between two or more parties creating obligations that are enforceable or otherwise recognizable as law. 2. The writing that sets forth such an agreement. 3. A promise or set of promises by a party to a transaction, enforceable or otherwise recognizable at law; the writing expressing that promise or set of promises...8. Loosely, an enforceable agreement between two or more parties to do or not do a thing or set of things.[3]

John Murray states that a contract is an "abstract legal relationship" between parties that consists of enforceable rights and correlative enforceable duties.[4] Contracts can occur in written, spoken, or nonverbal forms of agreement. But the actual written or oral agreement is evidence of the contract, not the actual contract.[5] However, the above description of contract is not strictly adhered to. One example of such is to use contract to describe a sale.[6] Contracts arise out of the self-interest of the individuals involved who agree to a joint project due to the supposedly equal benefits each will receive.[7] Contracts provide a legally enforceable means for all involved parties to protect their own interests and hold the other parties accountable to the terms of the agreement.[8]

Murray gives six essential elements of contract. These are "(1) mutual assent; (2) consideration of some validation device; (3) two or more contracting parties; (4) an agreement that is sufficiently definite; (5) parties that have a legal capacity to make a contract; (6) no legal prohibition precluding the formation of a contract."[9] West's Encyclopedia of American Law includes among a legal contract's elements an offer and acceptance which Murray terms mutual assent. West's also includes the agreement being placed in writing if required.[10]

There are different types of contracts. The typical contract parties enter into is a bilateral contract. Black's Law Dictionary defines a bilateral contract as "a contract in which each party promises a performance, so that each party is an obligor on that party's own promise; a contract in which the parties obligate themselves reciprocally, so that the obligation of one party is correlative to the obligation of the other."[11] Bilateral contracts must include promises on the part of both parties and a mutuality of obligations.[12]

A unilateral contract, by contrast, involves only one promise. The promisor in these contracts desires an act from the promisee in exchange for the promise.[13] The promisee cannot be forced to act, but if he or she does, the promisor must fulfill the contract. An example of a unilateral contract is a reward offer.[14]

Another type of contract is an implied-in-fact contract that has mutual agreement of obligations that are not expressed orally or in writing.[15] An implied-in-law or quasi-contract is not a true contract as no promise is involved. Quasi-contracts result in restitution when one party is unjustly enriched at the other's expense.[16] Implied contracts cannot harm one of the involved parties. Contracts implied-in-fact define the obligations mutually agreed to whereas with quasi-contracts the duty defines and imposes the agreement upon the parties.[17]

Contracts are considered voidable by an involved party if fraud is involved or if one party is not legally competent to enter into a contract, such as infants.[18] An enforceable contract is one that the court will enforce if the promise is not fulfilled by one of the parties. If the court recognizes the existence of the contract, but decides not to enforce it, it is unenforceable.[19]

6.2b Promise, Obligation, Duty

The moral principle underlying contracts is the keeping of the agreed to promises on the part of all involved parties or keeping one's word. Merriam-Webster Online Dictionary defines promise as:

> a declaration that one will do or refrain from doing something specified; a legally binding declaration that gives the person to whom it is made a right to expect or to claim the performance or forebearance of a specified act; to pledge to do, bring about, or provide.[20]

Keeping promises allows a contract to endure. Without this underlying promise there is no contract. David Novak writes:

> a contract presupposes the norm that promises are to be kept (pacta sunt servanda). Without this presupposition, a contract would have no duration and would be, therefore, meaningless.[21]

The moral principle of keeping promises creates an obligation. West's Encyclopedia defines obligation as:

> a generic term for any type of legal duty or liability…Currently obligation is used in reference to anything that an individual is required to do because of a promise, vow, oath, contract, or law. It refers to a legal or moral duty that an individual can be forced to perform or penalized for neglecting to perform.[22]

A contractual agreement legally obligates one or more of the involved parties to provide certain goods or services as promised in exchange for some other service or payment. A moral obligation may not be legally enforceable but it is considered binding upon one's conscience.[23]

A central question of contract law is which contractual promises should be enforced by the law. However, this is not the same as the question of which promises individuals should keep.[24] Throughout history the law has chosen not to enforce all contractual promises. Some current examples are donative or gift promises that do not

cause injury and social promises.[25] The United States legal system has never addressed the issue of whether all promises should be enforced by law or set up criteria to determine this. Instead, which promises are legally enforced by the courts has evolved and changed over time.[26]

Moral obligation was a basis for enforcing promises in England starting in the 1700's. However, the court stopped this on the grounds that it could not put satisfactory limits on the concept as promise itself creates a moral obligation to fulfill the promise.[27] United States courts have similarly rejected moral obligation to validate contracts for the same reasons.[28]

Contracts are breached when one party fails to perform all or part of agreed upon obligations.[29] Failing to perform all or a part of a contract that results in denying the other party from receiving the benefits of the contract is a material breach.[30] Remedies for a breach of contract include awarding monetary damages to the injured party, rescission of contract which terminates the contract, restitution which restores the injured party to where the party was before entering into the contract, reformation of the contract, and specific performance which requires fulfillment of the contract's promise.[31] Minor breaches are considered slight deviations from fulfilling the contract's promise.[32] Contract can be proposed as a possible common normative model for resolving maternal-fetal conflict as it would spell out the minimal obligations of the pregnant woman to her fetus. The concept of a maternal-fetal contract is examined in a subsequent section.

6.2c Physician – Patient Model

The normative contract model is used in medicine to describe the physician-patient relationship. The physician-patient relationship is legally viewed as a contract into

which autonomous individual freely enter or decide to end.[33] The physician-patient contract is rooted in mutual respect for both the physician's and patient's roles in the relationship, including each one's rights, duties, and autonomy.[34] The idea of a medical contract assumes a level playing field upon which the physician and patient or other involved parties possess the capacity to give and receive information and make decisions.[35] William F. May believes that informed consent is the basis for the physician-patient contract, which allows the two to reach an agreement concerning the patient's treatment and payment for services.[36] May states "the net effect is to establish some symmetry and mutuality in the relationship between doctor and patient."[37] The medical contract has two essential features according to Benedict Ashley and Kevin O'Rourke. First the contract limits the obligations of the physician to his or her specific role. Second is trust, which results from the physician's concern for the patient, medical knowledge and skills, and adequate communication with the patient.[38] One of the criticisms of the above physician-patient contract model is that it results in a minimalist approach of what is required by the physician, specifying services and fees.[39] Another criticism is that it neglects the care aspect of medicine.[40] Contract is also criticized as lacking the virtues of self-effacement, self-sacrifice, compassion, and integrity. Laurence McCullough and Frank Chervenak believe these four virtues make the physician-patient relationship moral and other-regarding.[41]

The physician-patient relationship is also described as a fiduciary relationship which involves a duty of loyalty to the patient by the physician. The physician is to act for the patient's benefit, placing the patient's interests above the physician's own. The physician's duty also involves trust.[42] McCullough and Chervenak give three conditions

of the physician as fiduciary which they say are lacking in a contractual physician-patient relationship. These are "the physician, as fiduciary, (1) must be in a position to know reliably the patient's interests, (2) should be concerned primarily with protecting and promoting the interests of the patient, and (3) should be concerned only secondarily with protecting and promoting the physician's own interests."[43] The fiduciary relationship also involves the above discussed four virtues that make the physician-patient relationship moral. The physician-patient relationship as a contractual or fiduciary relationship is discussed in a subsequent section as possible common normative ground for resolving maternal-fetal conflict.

6.2d Maternal-Fetal Model

The concept of a legal contractual agreement can be proposed as a common normative model for resolving situations of maternal-fetal conflict. As with the physician-patient contract, the maternal-fetal contract spells out the minimum of what is required by the pregnant woman and limits her obligations to her role as mother-to-be to the fetus. A maternal-fetal contract has the advantage of informing all involved parties of the pregnant woman's duties to her fetus in a situation of maternal-fetal conflict. Disagreement is easily resolved, making contract an ideal model.

In reality, no maternal-fetal contract exists. Contracts, by definition, involve an agreement between two parties and a promise or set of promises.[44] Both parties entering into a contract must have decision-making capacity. Since the fetus lacks decision-making capacity, it is not legally competent to enter into any type of contract. Even though the contract can be oral, written, or unspoken, the fetus is unable to communicate with the pregnant woman or anyone else in any manner, also precluding the fetus from

entering into any type of contract. Informed consent from the fetus is not possible. Nor is it possible for the fetus and the pregnant woman to agree on the terms of services and goods that make up the contract or to make any promises. Symmetry and mutuality cannot be achieved. The fetus also cannot undertake any action required to fulfill a unilateral contract.

Besides being unable to make any promises as a part of a contract, the fetus is incapable of keeping any promises or fulfilling the obligation that is created by the promise. Contracts are meaningless if promises are not kept.[45] The fetus cannot be forced to perform or penalized for not performing an obligation as it is incapable of doing so. The fetus grows and develops in the uterus while moving about the uterus. Even if growing and developing normally is delineated as the promise the fetus is to keep, the fetus has no control over these activities. The fetus' growth and development is the result of many factors such as genetic, the in-utero environment, and the pregnant woman's health and activities. None of these are performed by the fetus. The fetus responds to the conditions presented to it. The fetus does not choose to grow and develop or not grow and develop normally. The fetus cannot keep any promise or the obligation that the promise creates. Therefore, no contract exists.

One might say that the fetus and pregnant woman can enter into an implied contract, specifically an implied-in-fact contract that is not expressed orally or in writing.[46] The implied-in-fact contract is based on the assumption that the fetus desires to be born. R. M. Hare believes "the reason why most of us think that all things being equal pregnancies should not be terminated, is that we think that on the whole they are likely to result in people being born who will in the course of their lives, be glad to have been

born."[47] The implied-in-fact contract is a true contract as there is no inequity or harm to the fetus, either of which would not allow for an implied contract.[48] But once again, there is no way for the fetus to communicate, to make its views known as to whether it wishes to actually be born. Also, there is no mutual agreement of obligations between the pregnant woman and fetus. West's Encyclopedia of American Law states "if one party does not actually bind himself or herself to some performance or forebearance, it is an illusory promise and there is no enforceable contract."[49] The fetus is physically bound to the pregnant woman, but that is the extent of its abilities. The fetus cannot bind itself to some performance. Therefore, only an illusory promise exists and there is no implied contract. A true implied-in-law or quasi-contract also does not exist as restitution is not being sought.

Concerning contracts and the pregnant woman who chooses to continue her pregnancy, Joel Jay Finer writes:

> Once the time for a lawful abortion has passed, the mother implicitly undertakes to care for her fetus and bring it to life in as healthy a condition as she can without shouldering an unreasonable burden. Although such an undertaking cannot be said to be a contractual undertaking, as there is no agreement and no consideration, the imposition of quasi-contractual duties - contractual duties by virtue of public policy – seems reasonable. One who assumes a duty by contract, such as a fire-fighter or bomb-squad member, may be required to take a higher risk than one who has a duty by virtue of relationship only. So it might be argued that the mother has agreed to take, not whatever risks are reasonable in the abstract, but whatever risks are reasonable to bring about the birth of a healthy child.[50]

As Finer states above, no actual contract exists between the pregnant woman and her fetus or between the pregnant woman and her physician. As previously discussed in chapter two, courts ruled that a pregnant woman's autonomy is grounded in liberty interests. These liberty interests in autonomous decision-making, however, may be

outweighed by state interests in the developing fetus. Any so called contract made by the pregnant woman with her fetus really states that the pregnant woman is obligated to see the fetus to a live birth only if she chooses to do so. She is under no legal obligation to continue her pregnancy until birth, even if she has chosen not to have an abortion when legally permissible. As discussed in chapter two, she is not consistently legally obligated to undergo any medical or surgical procedure to benefit her fetus' health.

The courts, when they do not compel treatment for the fetus' benefit, allow the pregnant woman an out to any type of contract she made with her fetus or physician. The pregnant woman, in this case, will not be held for breach of contract with the fetus. The pregnant woman cannot be held to the typical remedy of specific performance. West's Encyclopedia defines this as "an equitable remedy by which a person is required to execute, as nearly as practical, a promised performance because monetary damages are inadequate to compensate for the breach."[51] Using this standard requires overriding the pregnant woman's autonomy and liberty rights so she can fulfill the contract with her fetus and bring it to a live birth. The pregnant woman also is not required to pay any monetary damages if treatment is not compelled for the fetus' benefit, resulting in harm or death to the fetus.

Concerning the assumption that when a pregnant woman does not have a legal abortion, Mary Anne Warren writes:

> [she] has voluntarily waived her right to refuse any such medical interventions. But the very fact that some women decline to undergo surgery which their physicians regard as potentially beneficial to the fetus shows that they have not voluntarily waived that right. The model which this argument presupposes is not that of the voluntary waiving of rights, but rather that of involuntary forfeiture. The presupposition, in other words, is that any woman who elects to continue rather than abort a

> pregnancy thereby forfeits fundamental legal rights enjoyed by all (other) competent adults who have been convicted of no crime.[52]

The AMA also disagrees with the argument that a woman who does not have an abortion has a legal duty to do what is necessary to bring her fetus to a live birth. The AMA interprets this as some individuals believing that the pregnant woman who fails to have an abortion forfeits her liberty rights.[53] But the AMA points out pregnant women never actually waive their liberty rights at any point in pregnancy.[54]

Only if the pregnant woman believes she has a moral obligation to keep the theoretical contract that she made with her fetus or physician will she be obligated to act for the fetus' benefit. The pregnant woman in this situation may believe she is obligated to keep her promise to do what is necessary to bring the fetus to a live birth, even if it inconveniences her in some way or only benefits the fetus. The moral duty may result from the pregnant woman's belief that beneficence and nonmaleficence towards her fetus are more important than her autonomy and legal rights. Or one might say she makes an autonomous decision to act for the benefit of her fetus. The pregnant woman may also believe she has a moral obligation based on deontological theories that require one never to lie or break a promise. She may also believe she has a moral obligation to her fetus as her future child as discussed in chapter three.

However, courts in the United States do not enforce promises based on moral obligations.[55] Courts do not use moral obligation to compel treatment. Specifically, courts have refused to enforce a moral obligation to donate bone marrow as seen in the case of McFall v. Shimp.[56] The court rejected a claim to compel Shimp to donate his bone marrow to McFall in an attempt to save McFall's life. The court recognized that

Shimp had a moral obligation to donate, but not a legal one.[57] Courts have also refused to enforce a moral obligation to marry, as seen in Short v. Stotts.[58]

Another legal concept to be considered to resolve a situation of maternal-fetal conflict is nonfeasance. Black's Law Dictionary defines nonfeasance as "the failure to act when a duty to act existed."[59] Nonfeasance comes from tort law, describing a failure to act that causes harm.[60] West's Encyclopedia of American Law states "an act of nonfeasance can result in liability if (1) the actor owed a duty of care toward the injured person, (2) the actor failed to act on that duty, and (3) the failure to act resulted in injury."[61] A preexisting relationship between individuals is usually required by the courts, such as parent and child.[62]

Situations of maternal-fetal conflict can fit this legal concept of nonfeasance. A preexisting relationship is present between the pregnant woman and her fetus. As discussed in chapters two and three, courts and philosophers agree the pregnant woman has a duty to care for her fetus, although disagreement exists as to the limits of this duty. If one believes the pregnant woman has a duty, legal or ethical, to act for the benefit of her fetus when her life is not endangered, then refusing to do so is a failure to act. In this dissertation's case, the pregnant woman not undergoing the cesarean section for her fetus' benefit is the failure to act. Not having the cesarean section results in injury to the fetus – the death or serious harm to the fetus.

But as discussed previously, legal, philosophical, professional medical organizations, and religious theories are inconsistent as to the pregnant woman's duties to her fetus. Only if one believes legally or ethically the pregnant woman has a duty to her fetus and failed to act, resulting in harm to the fetus, does nonfeasance apply.

One can consider the normative contract model from the physician-patient perspective since a true maternal-fetal legal contract cannot exist. Ruth Macklin discusses three contract models that can be negotiated between the physician and pregnant woman. The first, called a "gynecological" contract, only takes into consideration the woman's "health, welfare, and desires."[63] The fetus is considered or is a patient only if the pregnant woman chooses to make it one. The second contract is a "pediatric" contract. Concerning the pediatric contract, Macklin writes:

> the fetus is a patient by virtue of the woman's therapeutic contract. 'By extreme contrast with gynecological contract, the woman's health is made secondary; therapy is to be guided by fetal considerations.' The third contract, the 'obstetrical' one, is more qualified. On this model the commitment is to the successful outcome of pregnancy, namely a healthy baby.[64]

The obstetrical contract falls in between the gynecological and pediatrics contracts. According to Macklin, the ethical problem with viewing the maternal-fetal relationship as a contract the pregnant woman makes with her physician:

> is the worry that such 'contracts' could be treated as binding even if the woman decided to change her mind somewhere along the way. It is the nature of the voluntary informed consent to treatment that a patient may refuse the treatment or reverse an earlier implied consent.[65]

A contract also has the danger of the minimalist approach, specifying the pregnant woman's minimal legal obligations to her fetus. Moral obligations of the pregnant woman to her fetus may be overlooked in a contract and unenforceable by a court. The contract may also reflect the self-interest of the pregnant woman and neglect care of the fetus.[66] Like the physician-patient contract model, virtue is missing from the maternal-fetal contract model.

The maternal-fetal relationship, similar to the physician-patient relationship, is also described as a fiduciary relationship. McCullough and Chervenak believe this fiduciary relationship has an ethical basis, though not necessarily a legal basis, that the pregnant woman cannot ignore.[67] The duty involved in this maternal-fetal fiduciary relationship is based in trust and loyalty and requires the pregnant woman to act for the fetus' benefit, putting the fetus' interests above her own.[68] But, like contracts, enforcing this fiduciary relationship requires the courts to override the pregnant woman's autonomy and liberty rights. Similar to moral obligation, the fiduciary relationship is not used by the courts as a basis for compelling treatment of a pregnant woman for her fetus' benefit, but it can be appealed to as an ethical duty of the pregnant woman to her fetus.

The physician also has a fiduciary relationship with the pregnant woman and fetus, requiring the physician to act for their benefit. However, as discussed in chapter four, the problem becomes whether the pregnant woman and fetus are viewed as one patient or two patients by the physician when determining the best interests of the pregnant woman and fetus.

6.2e Summary

The idea of legal contract is insufficient as a normative approach for resolving the questions presented in this dissertation for several reasons. First, as stated above, the pregnant woman's legal right to refuse medical care or treatment carries no obligation to undergo a treatment or procedure for the benefit of her fetus. Second, the fetus is unable to actually enter into any contract or agreement with the pregnant woman. Third, the pregnant woman cannot be held to specific performance for breaching the contract. Conflicts can still occur between pregnant woman, their physicians, and others involved

in the pregnant woman's care due to differences in the legal and moral requirements of contract in this situation. Therefore, contract will not provide a common distinct alternative normative model for resolving maternal-fetal conflict.

Since legal contract is inadequate as a normative approach there is no point in pursuing contract in the context of the physician-patient relationship. For example, there are different models of contract that a pregnant woman can make with her physician. These models vary in how the fetus is viewed by the pregnant woman and her physician, impacting the care and treatment that the fetus receives. The pregnant woman and her physician may not agree on which model is appropriate. The pregnant woman also has the option to decline or change her mind about her care and treatment at any point in the pregnancy, regardless of whatever previous decisions she made or contracts she entered into with her physicians. The physician – patient contract model also has the limitation of specifying minimal duties, self-interest, and neglecting care.[69]

The case of abortion can be enlightening. Not having an abortion when legally permissible does not create a contract with the fetus or a promise by the pregnant woman to bring her fetus to a live birth. The refusal of abortion may create a role obligation in some authors' opinions.[70] But whether this role obligation actually exists depends upon whether the pregnant woman believes she has a duty or moral obligation to her fetus as her child to be. In sum, legal contract does not provide a common normative approach or theory for resolving situations of maternal-fetal conflict.

6.3 Hermeneutical Stance

Based on the above, one can conclude that there is no agreed upon normative approach or theory to provide common ground for all involved parties in resolving a

situation of maternal-fetal conflict. The pregnant woman must make an ethical decision based upon these limited normative theories and approaches despite their inconsistencies. However, more can be accomplished by the woman than merely acceding to this unsatisfactory normative reality. The woman can provide depth of meaning to her autonomous decision that transcends the limited range of these normative categories. The advantage of this approach is to build a bridge between normative and virtue discourse in bioethics. That is, despite the normative ambivalence upon which she is forced to make her autonomous decision, she can adopt a hermeneutical stance that provides depth of meaning to her decision in a manner that enlightens her personal character as a function of virtue ethics. The hermeneutical stance occurs when the woman seeks to clarify her ethical decision based on inadequate normative categories by understanding this developing relationship with her fetus that has occurred throughout her pregnancy. Her autonomous decision should be consistent with this interpretation of her relationship with her fetus from the beginning of the pregnancy up to the point of maternal-fetal conflict. Her interpretation of her relationship with her fetus is a hermeneutical approach or stance.[71] The analysis that follows explains the meaning of this hermeneutical stance as a way of connecting the ethical decision that arises from the restrictive normative categories with character formation and virtue ethics by focusing upon the depth of meaning that can be aligned with the woman's autonomous decision.

6.3a Definition

Hermeneutics typically refers to the understanding and interpretation of a written text.[72] Hermeneutic philosophy sees human life as interpreting and giving meaning to the world, enabling individuals to know what to do in certain situations since they are able to

interpret the situation.[73] Perspectives of hermeneutics in bioethics involve interpreting medical decisions or choices in the context of the individual's life narrative and as a text that has meaning given to it by the individual.[74] Understanding and interpreting a decision or choice involves making sense of it based on one's previous experiences and expectations, yet being open and receptive to other perspectives when it does not fit with these.[75] Roberto Mordacci writes "the challenge of the moral decision is that it asks from the subjects the willingness to elaborate an original and authentic interpretation of the meaning of the practice, of which their choices and acts will be historically concrete ways of expression; in other words, the challenge for the actor is to be faithful to the essential core meaning of the practice."[76]

Hermeneutics enables an action or decision to elicit depth of meaning from the larger context of the agent's life or history. In an analysis of hermeneutics and ethical theory, William O'Neill explains that eliciting this depth of meaning requires recognition of the broader context of an agent's life with what he calls the agent's pre-understandings. Pre-understandings are what we already know, the knowledge we bring to any experience.[77] These pre-understandings both limit our understanding of events and allow us to understand new experiences and expand our knowledge.[78] One comes to any new experience or decision with pre-understanding which helps one to understand and interpret the new experience.[79] In other words, for O'Neill, understanding "is 'always, already' situated within the unfolding stream of life and thought."[80] Understanding is a "fusion of horizons," a merging of past and present and does not exist independent of tradition.[81] A person can only interpret a particular situation within the context of his or

her own history. The individual cannot separate his or her personal situation, experience, and knowledge from his or her understanding of the situation.[82]

6.3b Maternal-Fetal Relationship

This view of hermeneutics that clarifies the importance of understanding and interpretation highlights the significance of the maternal-fetal relationship when engaging maternal-fetal conflicts. The pregnant woman can interpret the developing relationship she has had with her fetus from the beginning of the pregnancy up to the point in time when the situation of maternal-fetal conflict occurs. In this dissertation's example, that is the point where undergoing a cesarean section to save the life of or to prevent serious harm to her fetus is recommended by the obstetrician. Her life is not endangered.

The maternal-fetal relationship is the text that the pregnant woman looks at to find its original meaning. She gives meaning to this relationship by understanding it based on her preexisting knowledge, experience, and expectations for her relationship with her fetus, what O'Neill calls her pre-understandings. These may be a result of, for example, previous pregnancy experiences, what she reads, or what others tell her. She may then interpret her relationship with her fetus, based on these pre-understandings, from a detached perspective, as simply providing a place for the fetus to grow and develop, as a parental relationship, or in some other manner. But the hermeneutical stance also is based on being open and receptive to other perspectives and understandings of the maternal-fetal relationship when it does not fit with the pregnant woman's expectations.[83] This is a fusion of horizons, the fusion of past and present. Understanding the new experience, the present maternal-fetal relationship, also expands the pregnant woman's knowledge.

The pregnant woman's interpretation of this developing relationship with her fetus throughout her pregnancy can give a depth of ethical meaning to her autonomous decision whether to undergo the cesarean section. Her autonomous decision is based on the normative ambivalence discussed previously given the lack of a consistent normative approach or theory for decision-making. The autonomous decision should be consistent with her interpretation of this maternal-fetal relationship.[84]

The pregnant woman's hermeneutical stance can be based on the Judeo-Christian biblical covenant relationship between God and humans. The pregnant woman can interpret this developing relationship, including her commitment to her fetus throughout her pregnancy, as a covenant relationship. The biblical view of covenant can clarify her decision as a gift freely given to her fetus which reflects her love for her fetus and is based in faithfulness and fidelity. The hermeneutical stance can give depth of meaning to the woman's autonomous decision to have the cesarean section to save the life of or prevent serious harm to her term viable fetus when her life is not endangered. By deciding in a context that is normatively ambivalent, this hermeneutical stance can also enlighten the pregnant woman's character and virtue in the process.

The approach of hermeneutics highlights the importance of understanding the maternal-fetal relationship as a covenant relationship. The pregnant woman comes to the new experience of this particular maternal-fetal relationship with her pre-understanding of Judeo-Christian biblical covenant relationships. The pregnant woman's understanding of the meaning of a covenant relationship involves not only the biblical authors' meanings, but also the pregnant woman's historical situation and what covenant relationship means for her. The pregnant woman's understanding of covenant

relationship can vary based on her interpretation and knowledge of scripture. The pregnant woman's knowledge of maternal-fetal relationships is a fusion of medical and scientific knowledge and the pregnant woman's pre-understanding of pregnancy as discussed above. Many different sources and experiences can shape the pregnant woman's knowledge of the maternal-fetal relationship and pregnancy.

The pregnant woman can then interpret her relationship with her fetus as a covenant relationship based on her understanding, both past and present, of covenant relationship, maternal-fetal relationship, and pregnancy. Interpreting her maternal-fetal relationship as such expands her understanding of covenant relationship and the maternal-fetal relationship. The new experience expands her knowledge and pre-understandings, resulting in the hermeneutical circle. Finally, she is able to apply this hermeneutical stance to the autonomous decision she made whether to undergo the cesarean section. Her interpretation of her developing relationship with her fetus as a covenant relationship gives meaning to her autonomous decision.

6.4 Biblical Covenant Relationships

Similar to the concept of contracts is the idea of covenant. Covenant, according to Merriam-Webster Online Dictionary and Thesaurus, means:

> a formal agreement between two or more nations of peoples; a formal agreement to fulfill an obligation; an arrangement about an action to be taken; to make a solemn declaration of intent; a treaty.[85]

A legal covenant is defined by West's Encyclopedia of American Law as:

> an agreement, contract, or written promise between two individuals that frequently constitutes a pledge to do or refrain from doing something… Covenants are really a type of contractual agreement that if validly reached, is enforceable by a court.[86]

An absolute covenant, according to Black's Law Dictionary, "is not qualified or limited by any condition," whereas a conditioned covenant is limited or qualified by certain conditions.[87] Covenant differs from a contract in that the involved parties are not necessarily equal in terms of power, responsibilities, and moral possibilities.[88] Like legal contracts, the moral principle underlying covenants is promises ought to be kept.

6.4a Covenant of Promise

Covenants date back to ancient times and are found in ancient Near East treaties.[89] The idea of covenants between nations, individuals, vassals, sovereigns, and suzerains was common in the ancient Near East culture and formed the basis for the biblical covenants between God and man.[90] Edwin Hui writes "one of the main emphasis of the biblical notion of covenant is the element of dependence in which one party (Israel) is to be totally dependent on the other (God)."[91] Covenant is described by Dennis Hollinger as the ideal relationship since a covenant relationship is one of deep trust and fidelity of the commitment one person makes to another.[92] Covenant contrasts with contracts which focus on the mutual protection of the parties from deception, injustice, and personal aggrandizement.[93] The Bible uses covenant, according to Hollinger, "to describe God's relationship with his people and their relationship with God…so we are then called to relate to other humans in the same manner."[94] The concept of covenant has been adopted as a hermeneutical construct to clarify the meaning of the relationship between God and humans.

There are two types of covenant relationships between God and humans found in the Old Testament in the Christian Bible or Hebrew Bible. These are a covenant of promise and a covenant treaty. The covenant of promise is also called an absolute

covenant or covenantal grant.[95] According to Avery Dulles, this covenant is "modeled on the free royal decree, is an unconditional divine gift and is usually understood to be irrevocable."[96] God does not demand or require anything from humans in this type of covenant relationship. The relationship is a reward or gift since mankind was faithful to God.[97] The covenant relationship has no conditions on humans for the future in order to sustain it and results from what humans have already done.

The first example of a covenant of promise is between God and Noah in Genesis. Noah enters into a partnership with God, agreeing to build an ark and take his family and two of every creature on earth to survive the flood.[98] The result is a covenant relationship between God and Noah. God remembers Noah and the others on the ark after the flood occurs and dries up the flood waters. Thomas Mann writes "God's remembering is the manifestation of his character as one who is faithful to his word."[99] God then outlines the covenant relationship with Noah in Genesis 9:8-17:

> 'I now establish My covenant with you and your offspring to come, and with every living thing that is with you – birds, cattle, and every wild best as well – all that have come out of the ark, every living thing on earth. I will maintain My covenant with you: never again shall all flesh be cut off by the waters of a flood, and never again shall there be a flood to destroy the earth.' God further said, 'This is the sign that I set for the covenant between Me and you, and every living creature with you, for all ages to come. I have set My bow in the clouds, and it shall serve as a sign of the covenant between Me and the earth. When I bring clouds over the earth, and the bow appears in the clouds, I will remember My covenant between Me and you and every living creature among all flesh, so that the waters shall never again become a flood to destroy all flesh. When the bow is in the clouds, I will see it and remember the everlasting covenant between God and all living creatures, all flesh that is on earth. That,' God said to Noah, 'shall be the sign of the covenant that I have established between Me and all flesh that is on earth.'[100]

God's covenant relationship is actually not just with Noah, but with all of Israel and mankind.

God's next covenant relationship is with Abraham and it is also a covenant of promise. Abraham meets God as El Shaddai, who becomes Abraham's God.[101] God promises to make Abraham the Father of many nations. God also promises Abraham and his descendents the land of Canaan.[102] Genesis 15:5-6 states:

> He took him outside and said, 'Look toward heaven and count the stars, if you are able to count them.' And He added, 'So shall your offspring be.' And because he put his trust in the Lord, He reckoned it to his merit.[103]

Genesis 17:4-8 states:

> 'As for Me, this is My covenant with you: You shall be the father of a multitude of nations. And you shall no longer be called Abram, but your name shall be Abraham, for I make you the father of a multitude of nations. I will make you exceedingly fertile, and make nations of you; and kings shall come forth from you. I will maintain My covenant between me and you, and your offspring to come, as an everlasting covenant throughout the ages, to be God to you and to your offspring to come. I give the land you sojourn in to you and your offspring to come, all the land of Canaan, as an everlasting possession. I will be their God.'[104]

God initiates this covenant relationship. Abraham only has to believe that God will be faithful.[105] As with Noah, God is faithful, dependable, and trustworthy in this unilateral covenant relationship with Abraham and all of Israel.[106] But God does introduce circumcision as an outward sign of the covenant relationship, which is to be passed on to each generation and to include non-Israelites.[107] W. Gunther Plaut writes "berit milah, the covenant of circumcision" confirms one's covenant relationship with God and not having a circumcision is a rejection of this covenant.[108]

6.4b Covenant Treaty

The second type of biblical covenant relationship is a covenant treaty which is conditional, with blessings bestowed on those who uphold the covenant and curses for those who do not.[109] The covenant treaty is based on the Suzeranian treaty, which was

common in the late 14th and 13th centuries BCE. These relationships were established unilaterally by the more powerful party out of benevolence. The suzerain promises to protect the vassal in exchange for the vassal following the laws of the suzerain.[110]

The Sinai covenant relationship between God and Israel in Exodus 19:1-24:18 is a conditional covenant relationship. God is the sovereign or suzerain and Israel is the vassal.[111] God, in this relationship, promises to protect Israel if Israel obeys God's commandments. Israel will now be God's "treasured possession and chosen people."[112] James King West writes:

> [God] acts as the powerful Lord of history who grants the covenant as a gift to the people of his own free choosing. Having proven his lordship in Exodus, he now offers a lasting alliance, requiring in return that Israel accept its role as his covenant people and respond in faithfulness to the instruction he offers. It is thus not a favor to be earned, but a grateful response to a love already demonstrated.[113]

Israel's Sinai covenant relationship is a result of God's grace, not merit.[114] The covenant relationship between God and Israel at Sinai is one of mutual love. God gives the gift of the covenant relationship to Israel as an act of love and Israel maintains the relationship out of love for God.[115] God's Sinai covenant relationship is with all of the people of Israel who agree to the relationship, binding themselves to God.[116]

The Sinai covenant relationship persists despite Israel's lack of faithfulness. Israel is first unfaithful shortly after the relationship is established. The Israelites worship the golden calf idol while Moses is on the mountain with God. At Moses urging, God forgives Israel and renews this covenant relationship with Israel.[117] Mann states:

> the renewal of the covenant itself is an act of divine grace, for in this decision Yahweh extends to Israel his protective and governing sovereignty, despite their breach of the original covenant…Yahweh has now reaffirmed his identity as Israel's suzerain, even though Israel is a rebellious vassal.[118]

> It is not just that grace is not a reward for righteousness; it is that grace is offered despite unrighteousness. Israel's failure to live up to the conditions of the covenant means a failure to achieve sanctification, but it does not negate Israel's salvation. Yahweh is still willing to call them 'my people,' as he was before they even knew of him (3:7-10). That relationship is rooted in Yahweh's unqualified love for the people…the text will never suggest a final and complete abandonment of Israel by God.[119]

Israel continued to be unfaithful over time, as seen throughout the Hebrew Bible or Old Testament, repeatedly breaching their covenant relationship with God.[120] But despite Israel's repeated transgressions, God never breaks the relationship even though the breaches ended Israel's claim to it.[121] God remains faithful to the covenant relationship and Israel.

6.4c New Testament Covenant Relationship

The covenant in the New Testament of the Christian Bible is the fulfillment of God's promise to send Jesus to redeem the world's sins. A new covenant relationship is established through Jesus' life, death, and resurrection, which is a gift from God to humans. The covenant relationship is available to all who wish to receive this gift of God's love and is a result of accepting discipleship and its responsibilities and rewards from God.[122] Discipleship consists of developing one's character in accordance with Christian virtues. Paul Ramsey describes God's covenant relationship with humans as:

> chesed, or God's keeping troth, his unwavering faithfulness in keeping the covenant. This word, usually translated, 'mercy' or 'loving-kindness,' means 'fixed, determined, almost stubborn steadfastness,' 'sure love,' 'love unswerving,' 'fidelity, firmness, truth,' 'firm adherence' and 'determined faithfulness to the covenant,' 'the strength, the firmness, and the persistence of God's sure love.' Such covenant – love of God provides the measure for the sort of fidelity men are due to give to the covenant.[123]

May believes that the covenant relationship between God and humans in the New Testament involves "gift answering gift" and is expressed in 1 John 4:10-11- "In this is love, not that we loved God, but that he loved us…if God so loved us, we ought to love one another."[124] Gift, theologically, is usually expressed as love described as charity or agape. The covenant relationship between God and human beings consists of gift-love and for Christians is embodied in Christ.[125] Concerning covenant in human relationships, William Werpehowski writes, that "God in Christ's being for others is the basis of the possibility that human beings may be with and for one another across the range of their relationships."[126] Christ's love for us in this world is what turns humans toward their neighbors in love.[127]

6.4d Summary

The above discussed biblical covenant relationships between God and humans are initiated by God, not humans. In the covenant of promise with Noah and Abraham, God requires nothing from Noah and Abraham and has no expectations in return for establishing these relationships. In the Sinai covenant with Israel, there are conditions. But Israel fails to fulfill them time and again. God freely reestablishes the covenant relationship each time. God does not expect anything from Israel since God does not require Israel to uphold its part of the covenant. God gives the gift of Jesus in the New Testament and establishes a new covenant relationship through Jesus' life, death, and resurrection. The covenant relationships are gifts freely given out of love.

6.5 Maternal-Fetal Covenant Relationship

The above biblical covenant relationships can be adopted by the pregnant woman as a way to interpret this developing relationship with her fetus throughout her pregnancy. The biblical covenant of promise is very similar to the maternal-fetal covenant relationship. First, both are unilateral covenants. Second, both are gracious, generous gifts given to another without further conditions on the recipient. Third, both are based in faithfulness and fidelity. Because of God's commitment to the covenant relationship in light of Israel's unfaithfulness, the Sinai covenant relationship is not truly bilateral. The Sinai covenant relationship in this sense is also a unilateral covenant relationship, similar to the maternal-fetal relationship. God's gift of Christ to humans is also reflected in the maternal-fetal covenant relationship. The pregnant woman lives out Christian virtues in this covenant relationship.

6.5a Similarities Between Biblical and Maternal-Fetal Covenant Relationships

Edward Langerak gives three features that biblical and human covenant relationships share that shape the character of and ground the covenant relationship.[128] These features are, according to Langerak:

> First they are rooted in events or actions, in gifts given or in mutual entrustments that result in the parties becoming vulnerable to each other. Second, these events or actions create a community whose identity is formed by and also helps form the identities of the individual members, a covenantal community that seeks both the common good and the good of each member. Third, covenants tend not only to endure over time but also to have their identity-shaping privileges and responsibilities affected by expected and unexpected developments in ways that typically cannot be specified in advance.[129]

These three features are present in the maternal-fetal covenant relationship. First, the maternal-fetal covenant is rooted in the pregnant woman's gift of her covenant relationship with her fetus. Second, the relationship creates the covenant community of the pregnant woman and her future child, forming the identities of both. The pregnant woman is seeking what is good for this relationship and considering how her actions will affect both her and her fetus. Lastly, the covenant relationship endures throughout the pregnancy, affected by all the events of the pregnancy, both expected and unexpected, including those leading to the situation of maternal-fetal conflict. The pregnant woman's relationship with her fetus includes a commitment to the fetus, which gives a depth of ethical meaning to her autonomous decision to undergo a cesarean section for her fetus' benefit when her life is not endangered. The pregnant woman, upon reflection of her relationship with her fetus, can see that this commitment to her fetus has an effect on both lives from the start, binding them to each other up to the point of maternal-fetal conflict.

6.5b Gift and Charity

The maternal-fetal covenant relationship is a freely given gift of the pregnant woman to her fetus. Merriam-Webster Online Dictionary and Thesaurus defines gift as "something voluntarily transferred by one person to another without compensation; something given to someone without expectation of a return."[130] Gift is not contractual in nature.[131] Paul Ramsey describes gift as "not rights to be claimed or duties to be imposed; the giver is not manifesting what should be naturally done, nor is he out of the continuities of life with life pursuing his own wholeness with that of another."[132]

The pregnant woman, upon examining this relationship with her fetus throughout the pregnancy, will realize that she is not expecting anything in return from her fetus.

The pregnant woman freely gives her fetus the gift of her body so it can grow and develop throughout the pregnancy. By doing so, the pregnant woman, transcends the self-interest and minimal requirements of a strictly contractual relationship.

Paul Camenisch defines gift as:

> (1) some value (2) intentionally bestowed by a donor who gives it primarily to benefit the recipient upon (3) a recipient who (a) accepts it knowing that it is given as a gift, (b) agreeing with the donor that it is a benefit, (c) who has no right to or claim upon it and (d) who is not expected to pay for it in the future in any way (i.e., in no specific way in which roughly equivalent value is returned); and (4) which brings into being a new moral relationship between recipient and donor, part of which consists of recipient obligations to the donor and the acceptance of limits upon the use of the gift.[133]

All four parts of Camenisch's definition are found in the pregnant woman's above described gift to her fetus. First, the gift is of ultimate value to the fetus as the gift gives life to the fetus. Second, the gift is intentionally bestowed by the pregnant woman on the fetus solely for the fetus' benefit. If the pregnant woman was attempting pregnancy, then she intended to give the gift of her body throughout the pregnancy to her fetus. Even if the pregnancy was not initially intended or planned, the pregnant woman allowed the fetus to continue to grow and develop in her uterus, intentionally continuing the pregnancy and the gift of her body to the fetus. Third, there is no obligation of payment on the future child's part. However, the fetus cannot directly accept the gift while in-utero. In fact, the gift cannot be acknowledged by the fetus until after it is born and develops the ability to reason. The fetus is a passive recipient of the gift of this relationship. Lastly, a new moral relationship of covenant is developed between the pregnant woman and fetus, but without any obligations on the part of the fetus, making this covenant relationship similar to the unilateral biblical covenant relationships.

Merriam-Webster Online Thesaurus lists beneficent and generosity as words related to gift.[134] The thesaurus describes generous as "giving or sharing in abundance and without hesitation" and beneficent as "having or showing a concern for the welfare of others."[135] Based on these meanings, the pregnant woman's gift of covenant relationship with her fetus can be described as generous and beneficent. Directly or indirectly, she shows concern for the fetus' welfare by sharing her body in abundance throughout the pregnancy with her fetus.

The pregnant woman's covenant relationship with her fetus theologically is expressed in love as charity. C. S. Lewis describes charity as Divine Gift-love or "Love Himself working in man."[136] Courtney Campbell further describes Lewis' charity as "gift-love" as:

> indiscriminate and universalistic in scope, personalized and self-giving in motive, and creative and reconciling in action. This gift-love structures the covenantal relations between God and humanity and, at least in the Christian tradition, is embodied fully in the person of Jesus. While persons are recipients of gift-love they also may express it in their relationships with others and may approximate the divine gift through such forms as affection, friendship, and eros.[137]

One such gift-love is the gift of life which humans imitate in procreation and is, according to Campbell, "self-giving rather than motivated by concerns of esteem or honor."[138] Charity as procreational gift-love is the unilateral love of the pregnant woman for her fetus throughout her pregnancy, the bond the pregnant woman has with her fetus. The love of the pregnant woman for her fetus is an expression of God's covenant and love for humans. God's covenant relationship with humans begins before we are born as seen in the biblical covenant relationship God has with King David in Psalm 139. God's covenant relationship with King David begins in the womb and is a result of God's grace,

love, and faithfulness.[139] Hui explains "it is God who has created, searched, known, surrounded, held and sustained David, who bears witness not so much to his relationship with God, but to God's relationship with him in a one-sided covenant of grace."[140]

Love as charity means love of one's neighbor.[141] According to Charles Curran, "charity refers to the love that we give in response to God's gracious gift of love to us."[142] With covenant relationship, love of neighbor is no longer just a general command to love all. Love of neighbor is now the love of the pregnant woman for her fetus. Langerak distinguishes between an "inclusive covenant" which sees all as our neighbor versus the "special covenant" in which certain individuals become our neighbor through specific actions and events.[143] An example of this is a parent-child covenant.

The pregnant woman interpreting the maternal-fetal relationship as a covenant relationship transforms love of neighbor to a "special covenant" relationship with the fetus. The special covenant love of neighbor of the pregnant woman for her fetus transcends self-interest and is centered on the fetus. The love of the pregnant woman for her fetus throughout the pregnancy is a reflection of the love God centers on humans in the biblical covenant relationship. B. Andrew Lustig describes love of neighbor centered on the other as "an open, immediate, uncalculating response to another's need."[144] The "special covenant" of love of neighbor in the maternal-fetal relationship is the open and immediate response of the pregnant woman to the fetus' need for her body to grow and develop throughout the pregnancy.

6.5c Faithfulness and Fidelity

The maternal-fetal covenant relationship, similar to the biblical covenant relationships, is based in the value of faithfulness. Merriam-Webster Online Dictionary

defines faithfulness as "steadfast in affection or allegiance; firm in adherence to promises."[145] The pregnant woman is steadfast in her allegiance to her fetus as God was to Noah, Abraham, and Israel. The pregnant woman did not terminate her pregnancy when legally permissible, instead continuing her pregnancy and relationship with her fetus from the beginning of pregnancy until the point of maternal-fetal conflict. Even if she was not conscious of it, the pregnant woman's faithfulness to her fetus has not wavered throughout the pregnancy, as she did not take any action to end this pregnancy. When faced with a situation of maternal-fetal conflict, with the exception of the rare case of the pregnant woman declining the recommended cesarean section in an attempt to end her pregnancy, the pregnant woman is still faithful to her fetus. She still desires the pregnancy and believes the fetus will be okay even if she does not have the cesarean section. Faithfulness to another keeps the ultimate end of the other before oneself. The pregnant woman keeps, consciously or unconsciously, the ultimate end of the fetus, a live birth, before her always throughout this relationship with her fetus.[146] The faithfulness to the fetus is reflected in the cases of Baby Boy Doe v. Mother Doe and Pemberton v. Tallahassee Memorial Regional Medical Center.

The pregnant woman's covenant relationship with her fetus is also based in the value of fidelity. Fidelity here is defined as loyalty and trust.[147] Edmund Pellegrino and David Thomasma believe "fidelity to trust becomes a sacred obligation to protect the well-being of the sick person."[148] The fetus is in need of special protection as it is totally helpless throughout the pregnancy and is dependent on the pregnant woman to protect its well-being. Fidelity also allows for favoritism."[149]

God's biblical covenant relationships are based in fidelity. God is loyal in the biblical covenant relationships, showing care and concern for Noah, Abraham, and Israel. God shows care and concern for Noah and his offspring by not letting them die in the flood, drying up the flood waters, and landing the ark in a place where Noah and his family could establish their household and community.[150] Similarly, God shows care and concern for Abraham by giving Abraham the land of Canaan, making Abraham very fertile in order to populate the land, and becoming their God.[151] God shows care and concern time and again for Israel. God sends Moses and the plagues on Egypt to convince pharaoh to free the Israelites from slavery.[152] God then protects Israel on the journey to the Promised Land once they leave Egypt, parting the Red Sea and destroying pharaoh's army.[153] God favors those chosen for the covenant relationship in both the Old Testament/Hebrew Bible and the New Testament.

The pregnant woman, reflecting on this relationship with her fetus throughout the pregnancy, can see that she is loyal, showing care and concern for her fetus. The pregnant woman favored her fetus' needs throughout the pregnancy. As illustrated in the court cases of forced cesarean section discussed in chapter two, usually the pregnant woman obtained prenatal care throughout the pregnancy. She saw her physicians and did what was recommended up to the point in the pregnancy where the maternal-fetal conflict occurs. Even after conflict occurred, in some cases she continued to see her physicians for prenatal care, such as in Baby Boy Doe v. Mother Doe.[154] The exception to this is the few instances where a pregnant woman did not obtain any prenatal medical care for whatever reason or when the pregnant woman does not return for care after the conflict occurs, such as in Jefferson v. Griffin Spalding County Hospital Authority.[155] However,

even then the pregnant woman sometimes went elsewhere for medical care as she was concerned about her fetus' welfare.

Trust is also a part of God's biblical covenant relationship. Noah trusted that God would protect him, his family, and the animals on the ark from the flood and provide for them afterwards. Abraham likewise trusted God. Without trust, these relationships would not have existed. Trust is also involved in God's covenant relationship with Israel. Israel trusted God as God protected them from pharaoh and led them out of Egypt. But despite the fact that Israel's trust in God wavered time and again, God's trust in Israel did not and the relationship endured.

The pregnant woman, upon reflecting on this relationship with her fetus throughout her pregnancy, can see that like the biblical covenant relationships, trust is involved. The pregnant woman trusts that she was doing, and will continue to do, the right things for herself and her fetus throughout the pregnancy, including making the right medical and nonmedical decisions for her and her fetus. She usually is not intending to harm herself or her fetus. So she trusts that her decisions and actions throughout the pregnancy are the correct ones for her and her fetus. She trusts that she is doing good for her fetus or at the very least not causing harm to her fetus.

6.5d Secular Covenant Relationship

The maternal-fetal covenant relationship can also be understood on a secular level. One does not have to view this covenant relationship as a Judeo-Christian religious biblically based covenant relationship. The secular covenant relationship is also a free gift of the pregnant woman to the fetus and reflects the love of the pregnant woman for her fetus. The secular covenant relationship is likewise based in the values of faithfulness

and fidelity. These concepts and values are not exclusively religious ones. They are a part of secular communities, society, and relationships, such as civil marriages, parent-child relationships, and friendships. As Hollinger observes "we also recognize that even men and women outside of faith in Christ are often able to reflect something of this covenantal dimension."[156] Therefore, the pregnant woman can interpret this developing relationship with her fetus throughout the pregnancy as a covenant relationship even if she is not receptive to the concept of the biblically based covenant relationship.

6.5e Virtue and Character

The hermeneutical stance based on biblical covenant relationships that gives meaning to the pregnant woman's autonomous decision whether to have the cesarean section highlights how the pregnant woman enlightens her virtue in the process. Virtue focuses on the character of the moral agent as opposed to the act, circumstances, or consequences.[157] Virtue focuses on the pregnant woman and not on the act of having the cesarean section, the circumstances surrounding the need for the cesarean section, or the consequences of whether she undergoes the cesarean section. Virtues are internal, according to Bruce Birch and Larry Rasmussen, being "habits of behavior nurtured in conduct."[158] Virtues make up the dispositions of persons and influence their actions.[159] Virtuous acts contain both right acts and right motives.[160] As Pellegrino and Thomasma write "virtue is a particular state of character, one that 'both brings into good condition the thing of which it is the excellence and makes the work of that thing be done well."[161] Doing a right act because of a wrong motive is not virtuous. Neither is doing a wrong act based on a right motive.

The pregnant woman, in making the autonomous decision to undergo the cesarean section for her fetus' benefit, is virtuous. Her autonomous decision contains a right act, undergoing the cesarean section, and a right motive, to benefit her fetus. By deciding in a context that is normatively ambivalent and inconsistent, the hermeneutical stance gives meaning to the pregnant woman's decision and can enlighten her character or virtue in the process. Adopting the hermeneutical stance can also further enlighten the pregnant woman's motive for having the cesarean section. Through the process of interpreting her developing relationship with her fetus, the pregnant woman becomes more aware of her own character and how it influenced her decision about the cesarean section. She becomes aware of why she chose to have the cesarean section and the knowledge she brings to this decision. The pregnant woman reflects on her understanding of her maternal-fetal relationship, helping her to consider her motives for adopting the hermeneutical stance and also the motives for her autonomous decision to undergo the cesarean section. She becomes aware of new knowledge that shapes her motives and influences her decisions, thereby affecting her character. Her virtue is enlightened as without the process of adopting the hermeneutical stance she may not consider or be aware of whether she is acting virtuously, if she is doing a right act with a right motive. She may not otherwise be aware of all she considers important in shaping her decisions.

6.5f Summary

The pregnant woman may not initially interpret this developing relationship with her fetus throughout the pregnancy as a covenant relationship based on her own previous knowledge, experience, and expectations. But, she should be open and receptive to other perspectives.[162] One such perspective is the concept of covenant. When presented with

the concept of covenant relationship, upon reflection, the pregnant woman may realize that a covenant relationship existed with her fetus throughout the pregnancy and choose to adopt this hermeneutical stance.

Hermeneutics involves the interpretation of a text. The meaning of the text should be consistent with the interpretation of the text.[163] The text here is the developing maternal-fetal relationship which includes the commitment of the pregnant woman to her fetus throughout the pregnancy. The maternal-fetal relationship is interpreted as a covenant relationship that gives ethical meaning to the pregnant woman's autonomous decision whether to undergo the cesarean section for her fetus' benefit. Her autonomous decision should be consistent with this hermeneutical stance. Consistency here is a normative decision to undergo the cesarean section based on one or more of the previously discussed legal, philosophical, religious, or professional medical organizations' theories or approaches.

6.6 Other Interpretations

The pregnant woman can interpret this developing relationship with her fetus as something other than a covenant relationship. One example of this is an ethic of care. But the covenant relationship, while having elements in common with an ethic of care, goes beyond it. The hermeneutical stance of covenant relationship differs from other views of the maternal-fetal covenant relationship and can be adopted to give meaning to the pregnant woman's relationship with various communities that she is a member of and to her relationship with her physician.

6.6a Covenant, Personhood, and Consent

Marjorie Maguire, in the article "Personhood, Covenant, and Abortion" writes that the covenant at Sinai was the start of personhood for Israel as a community. She views personhood as conferred on Israel through "a completely free and gracious gift on the part of Yahweh."[164] Maguire uses the Sinai covenant model as a normative theological approach to determining the beginning of personhood for humans. When the pregnant woman decides to continue or accept her pregnancy by not having an abortion, she makes a covenant, a free gift of herself, with the fetus as God did with Israel. The pregnant woman's covenant with her fetus confers personhood on the fetus according to Maguire.[165]

There are those who may believe using the terms covenant and covenantal love are too religious and poetic. Maguire suggests using consent of the pregnant woman to her pregnancy as a secular, universally acceptable term in place of covenant.[166] But consent, according to Merriam-Webster Online Dictionary, means merely to agree.[167] Covenant is more than consent. Covenant includes a commitment that the pregnant woman makes to her fetus. Consent does not. Hui believes that consent is not equal to covenant as covenant cannot be broken, whereas Maguire allows for a pregnant woman to rescind her consent for economic or social reasons.[168] Consent for Maguire is closer to a contract model of the maternal-fetal relationship, as discussed earlier, since a contract can be broken or rescinded at any point during pregnancy.

The free gift of the covenant relationship is more than just interpreting the maternal-fetal relationship as one of consent or agreement. The covenant relationship is reflected in the love of the pregnant woman for her fetus and based in the values of

fidelity and faithfulness. Consent, however, is not. Loyalty to the fetus is not present with consent. Neither is trust nor love. Maguire also speaks of the implicit consent to the pregnancy by the pregnant woman which occurs automatically after a certain point in the fetus' biological development is reached.[169] Again, implicit consent does not include a commitment to the fetus by the pregnant woman, instead occurring by default for Maguire.

Unlike Maguire's normative covenant model, the hermeneutical stance being proposed in this dissertation is not dependent on the personhood of the fetus. The pregnant woman can interpret her relationship with her fetus as a covenant relationship regardless of what her beliefs are concerning the status of her fetus as a person or the beliefs of others involved in her care. The covenant relationship does not require all the involved parties to agree on the status of the fetus. The relationship also is not dependent on whether one believes the fetus has rights due to a person.

6.6b Ethic of Care and Covenant

Interpreting the developing maternal-fetal relationship as an ethic of care is another hermeneutical stance that the pregnant woman can adopt. Ruth Groenhout explains that:

> care, the emotion involved in tending to the physical needs of other, dependent humans, holds a central place in ethical theory because of its indispensability for human life. Everyone who reaches adulthood does so because someone else cared for him or her.[170]

There are many different ideas about what an ethic of care entails. No one universal version exists in the literature. An ethic of care is most applicable in special relationship roles, such as health care provider, friend, and parent, which do not involve

impartiality.[171] Some philosophers believe an ethic of care consists of only person-to-person relationships. Other philosophers believe an ethic of care includes a political context and applies to the entire world, not just human interactions.[172]

The ethic of care is found in ancient Roman literature. The Latin term for care is cura, which has two meanings – worries, anxieties, or troubles and attentiveness or devotion to providing for the welfare of another.[173] The ethic of care also comes from the care of souls tradition which is the care of those who are troubled by a mental, physical, or spiritual difficulty that goes beyond physical life and refers to healing the entire person.[174]

An ethic of care also has its roots in psychological theory. Rollo May saw care as being objective in nature. Up to this point, care was viewed as a subjective experience.[175] May believes "care constitutes the basic constitutive phenomenon of human existence" and is needed to will, to love, and is the root of ethics.[176] Erik Erikson describes care as "the concrete concern for what has been generated by love, necessity, or accident; it is 'a widening commitment to take care of the persons, the products, and the ideas one has learned to care for."[177]

Contemporary ethic of care theories started with psychologist Carol Gilligan's work which showed woman tend to approach problems from an ethic of care centered on relationships with others.[178] Men, though, approach problems from a logical justice perspective.[179] The insights Gilligan views as central to an ethic of care are an "understanding of morality as arising from the recognition of relationship," a "belief in communication as the mode of conflict resolution," and a "conviction that the solution to the dilemma will follow from its compelling representation."[180] In contrast to this,

Gilligan finds that the male response to a dilemma consists of "hierarchical ordering, with its imagery of winning and losing and the potential for violence which it contains."[181] Isolation and aggression are avoided through activities of care as opposed to limits set by rules.[182] Gilligan writes:

> the moral imperative that emerges repeatedly in interviews with women is an injunction to care, a responsibility to discern and alleviate the 'real and recognizable trouble' of this world. For men, the moral imperative appears rather as an injunction to respect the rights of others and thus to protect from interference the rights to life and self-fulfillment."[183]

Equality, treating all the same, is the basis for an ethic of justice, whereas nonviolence, not hurting anyone, is at the basis of an ethic of care.[184] Gilligan's ethic of care has a psychological logic of relationships underlying it, with its central insight being the interdependency of self and others.[185]

Despite the above insights into care, Daryl Koehn believes Gilligan does not give an actual definition of care in her work.[186] Koehn does not see Gilligan as spelling out exact aspects of care. Rather, the different aspects that make up a definition of care must be derived from Gilligan's writings.[187] Koehn defines care, based on Gilligan's and Nel Noddings' writings, as an active concern for another that involves responding to his or her needs.[188]

Hilde Lindemann does define care. She puts forth three general features of care. The first is care requires and expresses a caring relationship. She believes "you have to care about the person you care for."[189] Next is you engage with another's will so they are not just the object of care for you but, she writes, "someone with wants, intentions, and desires of his own."[190] The third feature is care requires paying attention to particulars.[191] However, critics of an ethic of care argue that these three general features of care

reinforce sexist stereotypes of women and leave women open to exploitation, loss of integrity, and being oblivious to social justice.[192] Nel Noddings addresses exploitation by emphasizing moral education in caring.[193] Lindeman's features of care are somewhat similar to how Koehn defines care based on Gilligan's and Nel Noddings' writings.

Lindemann applies her ethic of care to mothering, stating that "the point of mothering is to bring about the child's well-being."[194] The three responsibilities involved in mothering are protection or keeping the child safe from harm, nurturance or fostering the child's growth, and training so the child can be a member of society.[195] The application of care to mothering can also be applied to the fetus. The point is the same for the pregnant woman – to bring about the fetus' or future child's well-being. Although a fetus cannot be trained to be a member of society in-utero, the fetus can be protected from harm and nurtured by the pregnant woman to foster its growth and development.

Nel Noddings sees the relationship between the one-caring and the cared-for as the essential element of caring.[196] Caring involves a commitment to the other and moving away from oneself.[197] Nodding believes "all caring involves engrossment."[198] Engrossment, for Noddings, means the reality of the one cared-for displaces the one-caring's reality and is seen as possibly one's own, leading one to care for the other and to act based on that caring.[199] However, the degree of engrossment can vary among caring relationships. The caring relationship also consists of comforting the one being cared for and desiring his or her well-being.[200] Noddings' ethic of care is similar in these ways to Lindemann's ethic of care.

Care for Noddings does involve an ethical obligation to care. According to Noddings, the obligation comes from:

> the value I place on the relatedness of caring. This value itself arises as a product of actual caring and being cared-for and my reflection on the goodness of these concrete caring situations.[201]

Affection and regard are part of the act of caring.[202] But Noddings believes that her ethic of care does not include a command to love or agape.[203] An ethic of care is not situation ethics that look at consequences of acts, but rather morality is found "primarily in the pre-act consciousness of the one-caring."[204] An ethic of care is also not based in a commandment from God to love or any type of universal love. Instead, Noddings ethic of care is based in human love and caring.[205] Agape, in Noddings' estimation, is based in a command to love others as a way to gain salvation, whereas care is a process of creating new relational selves.[206]

Sarah Hoagland disagrees with Noddings. She believes Noddings' ethic of care does include agape since agape is other-centered, like care, and not self-centered.[207] For Hoagland, agape's essence is found in the direction of loving. She writes "the caring of agape always moves away from itself and extends itself unconditionally."[208] Hoagland believes these values are found in Noddings' ethic of care.

Virginia Held interprets Noddings as emphasizing the attitudes involved in caring, whereas other philosophers emphasize care as labor or activity.[209] Held's ethic of care involves both.[210] Held sees the practice of care as an activity that connects people, building mutual concern and trust, and making those involved morally admirable people.[211] The values of care are found in caring relationships, between both individuals and in society.[212] According to Held, "all care involves attentiveness, sensitivity, and responding to needs."[213] Held believes "the ethics of care provides a way of thinking

about and evaluating both the more immediate and the more distant human relations with which to develop morally acceptable societies."[214]

Koehn defines care, based on Noddings' and Gilligan's work, as being "best conceived as an active, interpersonal, mutual reciprocity" which goes beyond mere concern for the other, instead being seen in one's activity.[215] Based on Koehn's definition, care only occurs between people, not things.[216] But Koehn believes when care in a profession is directed to a principled end, such as health and healing for health care professionals, then that is not genuine caring according to the ethic of care.[217] Koehn writes:

> true caring – or at least caring in the highest and most interesting sense – is an affective stance in which both the care-giver and cared-for put themselves at risk as part of a process of committing to the foregoing of a shared self. This is the kind of caring one sees in intimate, loving relationships.[218]

Koehn sums up the ethic of care as:

> ethical acts are caring ones of a certain sort. They are those acts in which the caregiver actively concerns herself with attending to the individually expressed needs, feelings, and interests of the cared-for and strives to create a shared self with people who are similarly committed to a secure world in which beings are nurtured and given an opportunity to realize fully their individuality.[219]

Care involves listening to the other in order to become engrossed with the other and form a connection with the other.[220] The demand upon all to be caring makes the ethic universal. Caring for the other causes others to care for us and is accomplished by one's actions. However, these do not include self-sacrifice or a requirement to love everyone.[221]

Rita Manning's ethic of care has two parts. First is a disposition or willingness to care, which involves a commitment to caring.[222] Second is an obligation to care and to

adopt the care model.[223] Manning defends this obligation to care based on three grounds. The first is need; that we ought to prevent something bad from happening if we can.[224] The second is recognizing continuous caring is required for human relationships, with continuous caring consisting of three parts – being receptive and accepting of the cared for and on call when needed for the other.[225] The third is active caring is required to develop and sustain the ability to care.[226]

Unlike Koehn, Manning believes caring can be the result of one's roles and relationships and their resulting obligations, such as a parent, teacher, etc.[227] For Manning, caring involves being open to the one being cared for and their needs and, unlike Koehn, may involve some self-sacrifice.[228] But she states:

> caring does not require feeling any particular emotion toward the one cared for, but an openness to the possibility that some emotional attachment may form in the process of caring for. Nor does it require an ongoing relationship with the one cared for.[229]

Manning also believes every need does not require a response. Care of infants, who are helpless, should be guided by what is in their best interests, encouraging their growth and development.[230] Manning's care of infants is similar to Lindemann's definition of mothering and can likewise be applied to care of the fetus.

Edward Vacek's care that is fully human requires wanting to do good and doing good. Care provides some benefit to the one cared-for.[231] But benevolence, according to Vacek, can be limited to a particular area of the other's life and for a limited time. Benevolence in care does not involve every aspect of the one cared-for's life.[232] Care also involves an obligation and responsibility to the one being cared for, along with hopefully some degree of affection. The degree of affection can range from none to being completely engrossed with the cared-for.[233] Vacek believes the degree of affection and

resulting relationship has an affect on our care for another, resulting in greater care for those with whom we have a special relationship. [234]

Ruth Groenhout also believes care is central to human life, with one example of this being mothering.[235] Mothering is defined by Groenhout as "the active tending of infants and children so that they live and grow insofar as that is possible."[236] Mothering includes teaching children what is necessary for them to become a participating member of society and the moral community.[237] Viewed in this way, Groenhout's and Lindemann's definitions of mothering are substantially similar.

Mothering demonstrates Groenhout's central feature of what she terms is "an adequate concept of care."[238] An adequate concept of care includes being actively involved in the cared-for's life, being committed to the other's good, having an intellectual, affective, and physical relationship at the same time with the cared-for, and the specific identities of the one-caring and cared-for being significant to the type of care given and received.[239] Groenhout also sees an ethic of care not only advocating caring actions, but requiring systematic thinking about social systems that support or make care giving difficult and their importance for moral theorists.[240]

Groenhout's definitions of care and mothering can be applied to the pregnant woman and her fetus. Mothering can be viewed as beginning during pregnancy. If the pregnant woman does not care for her fetus in-utero, the fetus will never have the opportunity to live and grow into a member of society and the moral community. Groehnhout's definition of care also requires the pregnant woman to be committed to the fetus' good based on the role or identity of the pregnant woman to her fetus.

Contrasting with Groenhout's ethic of care and mothering is Constance Perry's application of the ethic of care to the problem of forced cesarean sections. She believes care is an alternative to rights/interests models in these types of situations. Perry writes that care goes beyond emotions and "is a mode of practice where one is concerned for the individuals as people."[241] Care looks at the relationships and beliefs of the affected pregnant woman and how decisions and actions concerning her pregnancy fit into the full context of her life.[242] Using an ethic of care, the pregnant woman bases her decision about undergoing the cesarean section on how having or not having it affects her relationships with others in her life, such as the fetus, the fetus' father, family, etc.[243] The pregnant woman's relationship with her fetus may not be the primary concern in this context. In some cases, undergoing a cesarean section may put the pregnant woman's other relationships at risk and this should guide her decisions and even give support to refusing a cesarean section if she chooses to do so.[244]

There are multiple versions of an ethic of care theory, with the above being just a few representative examples. Each author has his or her own view of the theory. Central to all versions is that care involves relationships with others. However, differences occur between theories as to whether an ethic of care consists of values or activities or both. There are also differences in terms of what types of relationships constitute an ethic of care and what role, if any, affection, attachment, engrossment, and special relationships have in an ethic of care. The length of the relationship involved also matters. Mothering is believed to be representative of an ethic of care, with some of the above authors having similar definitions of mothering as care. But a consistent view of mothering as care does not translate into one model for resolving maternal-fetal conflict based on an ethic of

care. Mothering as care supports nurturing the growth of the fetus and protecting it from harm by having the cesarean section. By contrast, Perry uses the ethic of care to support the pregnant woman's refusal of the cesarean section, giving other relationships priority over the maternal-fetal relationship.

The maternal-fetal covenant relationship does share some common elements with an ethic of care. First, both can involve a commitment to the one being cared for as seen in Manning's, Nodding's, Koehn's, and Groenhout's ethic of care. Second, both occur in a relationship with another. Although the above authors view care as a bilateral relationship, care can be a unilateral relationship like the maternal-fetal covenant relationship. An example of this is one caring for a comatose individual who is unable to respond or communicate in any manner. Third, both the covenant relationship and care transcend the self-interest of the individual, being directed towards the other. Both involve doing good for the other. Fourth, care, in some cases, like the covenant relationship, can be a free gift flowing from one to another.

However, there are differences between the ethics of care and the maternal-fetal covenant relationship. The covenant relationship is not interpreted as the pregnant woman's role or duty to her fetus as it is in most care theories, except for Koehn's. Care, unlike covenant, for some authors, is not limited to relationships between persons, but can also apply to humans' relationships to the world.

Love is not necessarily included in an ethic of care. As discussed above, Noddings specifically states love is not a part of her ethic of care.[245] Sarah Hoagland does disagree with this view. Many authors believe affection for another is involved to varying degrees in care, but is not always required or present. As Manning explains, feeling

emotion for the other is not required with care.[246] Likewise, many of the authors include engrossment as a part of care, but engrossment does not necessarily require love or affection either. By contrast, the pregnant woman's covenant relationship with her fetus reflects the pregnant woman's love for her fetus. While love may be present in a care relationship, it is not an essential component of care and is not present in all care relationships. Examples may be care relationships involving family members and friends who act out of duty or obligation or those for whom care is part of their job. Love is not necessarily required in order to meet the needs of the one being cared for. While care, like the covenant relationship, may involve commitment to another, the two differ as to what forms the basis for the commitment and the level and extent of the commitment. A maternal-fetal covenant relationship goes beyond an ethic of care as care does not consistently require the one-caring to love the cared-for. The covenant relationship is not a result of duty.

Love is not included as part of mothering as care. Lindemann, Manning, and Groenhout all include nurturing the growth and development of infants and children as part of mothering as care. Lindemann and Groenhout include teaching the child to become part of society as part of mothering as care. Lindemann alone includes protecting the infant and child from harm as part of mothering and care. But none of these three include love or affection as a responsibility of mothering as care. The above responsibilities can be carried out without love or affection of the mother for her child. In fact, these responsibilities toward the infant or child can be carried out by any adult. No special relationship is required. Only if mothering as care is applied to the fetus is this relationship physically limited to the pregnant woman.

Care does not necessarily involve all aspects of the one cared-for's life.[247] Care, therefore, is not always present in a relationship. The maternal-fetal covenant relationship is enduring throughout the pregnancy and is not limited to a certain place or time as care can be. The maternal-fetal covenant relationship involves all aspects of the fetus' being and is an ongoing process throughout the pregnancy. Care may not always involve faithfulness and fidelity to the one cared for. Care is not always necessarily consistent and enduring. There can be varying degrees and types of care, resulting in different levels of relationships with the one being cared for. Faithfulness and fidelity can also be a result of one's role and the required duties and obligations to care. Faithfulness and fidelity to the covenant relationship are not a result of duty or obligation. The covenant relationship goes beyond care as the covenant relationship is ongoing, involving all aspects of the other's life.

6.6c Covenant Relationship and Community

The hermeneutical stance can also be adopted to give meaning to the pregnant woman's relationships with the various communities she belongs to. The covenant relationship at Sinai was between God and all the people of Israel as a community.[248] The relationship with God as a community is primary for Israel whereas the individual's relationship with God is indirect and secondary.[249] Mann writes:

> to be an Israelite means to be a member of a covenant community. Each individual Israelite does not and cannot stand alone, but is also bound to the covenant brother or sister.[250]

Each individual Israelite is required to balance his or her autonomy with the covenant commitment to the community.[251] The requirement falls to all of Israel's descendents over the ages, not just those present at Sinai. Likewise, God's covenant relationship in the

New Testament is open to the entire community. God gives the gift of redemption through Jesus out of love for all humans. Accepting God's gift makes one a disciple of Christ, a member of the community.[252] The idea of community also persists for present day and future disciples of Christ. Both the Jewish and Christian covenant communities seek the common good for all in the community along with what is good for individuals who are members of the community.[253]

The pregnant woman and her fetus belong to different communities. These communities may be her immediate and extended family, friends, church, work, neighborhood, state, and country. The pregnant woman's individual covenant relationship with her fetus can be interpreted as a reflection of her covenant relationship with these communities. The pregnant woman's covenant relationship with her family and different communities gives meaning to her autonomous decision to have the cesarean section and contribute another member to sustain these communities in the future.

Likewise, the various communities can adopt a similar hermeneutical stance with the pregnant woman and her fetus. The covenant relationship between the communities and the pregnant woman gives meaning to the various communities' financial, physical, and emotional support of the pregnant woman throughout the pregnancy along with enlightening the virtue of the communities. The lack of a covenant relationship between all those who are part of the human community results in the community not providing support and care to pregnant women and their fetuses and can lead to abortion.[254] As Karen Lebacqz explains, "the issue is one of covenant and community."[255] The pregnant woman and her fetus do not stand alone, but are bound in relationship to the communities, be it her family, state, work, or church group. All have a responsibility

toward the pregnant woman and her fetus to provide care and social structures that allow the pregnancy to flourish. The decision to support the pregnant woman and her fetus is given a depth of ethical meaning by interpreting the relationship as a covenant relationship.

6.6d Physician-Patient Covenant Relationship

The relationship between the pregnant woman and her physician can also be interpreted as a covenant relationship. The covenant relationship goes beyond rules, duties, individual rights, and doing the right thing as in a contractual relationship.[256] The covenant relationship is found in the character of the physician and pregnant woman, basing it in virtue, in being good people.[257] Like the biblical covenant relationships, the physician-patient covenant relationship is not a result of the patient's being worthy of receiving help.

As with the biblical relationships, the physician-patient covenant relationship is a gift. William F. May believes that the element of gift is what is missing from the physician-patient contractual relationship. A covenant relationship transcends the self-interest that forms the basis of contracts and contractual obligations.[258] The physician is present for the pregnant woman's physically, emotionally, and spiritually. Interpreting the physician-patient relationship as a covenant relationship gives meaning to the shared decisions the pregnant woman and her physician make concerning the pregnant woman's medical care and treatment. Understanding the relationship with his or her patient as a covenant relationship gives meaning to the physician's decision, for example, to personally care for a patient when not on-call.

6.6e Summary

As discussed above, the hermeneutical stance can also be adopted by the pregnant woman and the various communities she is a part of to give a depth of meaning to their normative decisions. The hermeneutical stance, while having much in common with an ethic of care, goes beyond the ethic of care as it is a freely given gift that has endured throughout the pregnancy. These features are not necessarily a part of care. The hermeneutical stance also goes beyond interpreting covenant as consent and is not dependent on one's view of the personhood of the fetus.

6.7 Applications of Covenant Relationship

There are many specific examples of clinical situations during pregnancy that can result in maternal-fetal conflict. Some situations that fit the dissertation example will be presented here.

6.7a Specific Clinical Examples of the Dissertation Case

The pregnant woman's hermeneutical perspective of understanding this developing relationship with her fetus throughout her pregnancy as a covenant relationship gives a depth of ethical meaning to the autonomous decision she makes in the case presented in this dissertation. The case is when a pregnant woman's obstetrician recommends a cesarean section to save the life of or to prevent serious harm to her term viable fetus. The pregnant woman's life is not endangered. There is no additional risk to the pregnant woman beyond that of a routine cesarean section. Examples of this type of situation are a non-reassuring fetal heart rate or fetal distress during labor, dystocia, cephalo-pelvic disproportion, and arrest of descent or dilatation.[259] Other cases when the

above scenario may occur include fetal malpresentations that are not candidates for version due to active labor, ruptured membranes, fetal presentation, or patient refusal, or if an attempted version is unsuccessful. Malpresentations that apply here are some transverse lies, breech presentations, face or brow presentations, or compound presentations.[260] Additional examples applicable to this dissertation's situation are umbilical cord prolapse, active maternal herpes outbreak or other infectious diseases that are transmittable to the fetus during labor, some cases of multiple gestations, and certain birth defects such as select neural tube defects, hydrocepahalus with macrocrania, and selected fetal abdominal wall defects such as extraabdominal liver involvement with omphalocele.[261]

The hermeneutical stance can also give a depth of ethical meaning to the pregnant woman's autonomous decision in any other situation occurring during pregnancy or labor where the physician or health care provider recommends a medical treatment or procedure solely for the fetus' benefit that does not put the pregnant woman's life or health at risk. One example is a pregnant woman who is advised to have a cerclage placed to treat or prevent cervical incompetence.[262] The procedure's purpose is to prevent a second trimester miscarriage. There is no medical benefit to the pregnant woman. Risks to the pregnant woman are typically minimal.

Other invasive procedures that fall into this category include amniocentesis to obtain amniotic fluid to test for fetal lung maturity, diagnose hemolytic disease of the newborn or other diseases, intrauterine transfusion to treat severe hemolytic disease of the newborn, or percutaneous vesicoamniotic shunts to treat selected cases of fetal urinary tract obstruction.[263] These procedures are done to treat medical conditions of the

fetus in-utero or to determine if the fetus can be delivered safely. In some cases, death or severe harm to the fetus can occur if these conditions are not diagnosed and treated prior to birth. Minimal risks to the pregnant woman from these procedures include bleeding and infection. The procedures are not treating a maternal condition.

Less invasive situations to which this covenant relationship may similarly give a depth of ethical meaning to the pregnant woman's autonomous decision include when the pregnant woman is advised to take an oral or intravenous medication for the fetus' benefit only. Examples include intravenous antibiotics during labor to prevent group B strep transmission from the pregnant woman to her fetus, steroids to promote fetal lung maturity, rhogam to prevent fetal hemolytic disease, or dexamethasone for the treatment of congenital adrenal hyperplasia to prevent masculinization of a female fetus' genitalia.[264] Risks to the pregnant woman include possible allergic reactions or side effects from the medications. None of these medications benefit the pregnant woman or treat a maternal condition in these situations. Examples of noninvasive treatment include anatomical ultrasound, non-stress testing, Doppler studies, and biophysical profiles to assess fetal well-being.[265] These noninvasive procedures are all for the fetus' benefit without any risks involved for the pregnant woman. They do not assess maternal well-being or diagnose maternal medical conditions.

Induction of labor for the fetus' benefit is very similar to this dissertation's situation. The physician may recommend delivery of a term viable fetus to prevent serious harm or death to the fetus, but may believe that it is safe to attempt induction of labor, hopefully resulting in a vaginal delivery. In these cases, there is no additional risk to the pregnant woman beyond an elective induction done at the pregnant woman's

request. The pregnant woman's life is not endangered. These type of situations may include non-reassuring fetal testing results, oligohydramnios, fetal growth restriction, post-dates pregnancy, isoimmunization, polyhydramnios, previous stillborn, and some fetal anomalies requiring specialized care.[266] Any time induction is attempted, there is the possibility that the induction may fail because of arrest of labor or the inability of the fetus to tolerate labor. When this occurs, a cesarean section is required for the fetus' benefit, resulting in a situation that is the same as that presented in this dissertation.

Any of these above situations can develop into a situation of maternal-fetal conflict, with a perceived incompatibility between the interests of the pregnant woman and fetus.[267] The pregnant woman and her physician may not agree on the appropriate course of treatment for some reason as discussed in chapter one. Interpreting the developing maternal-fetal relationship as a covenant relationship as proposed in this dissertation can be presented to the pregnant woman as a way to give a depth of ethical meaning to her autonomous decision. Her autonomous decision should be consistent with this hermeneutical stance. A third party knowledgeable of this perspective, such as a member of the ethics committee, clergy, another health care provider, or even a lawyer or hospital administrator, can propose this hermeneutical stance to give meaning to the pregnant woman's autonomous decision.

6.7b Use in Maternal-Fetal Conflict

A majority of the above situations are non-emergent situations which allow time for a fully informed consent process and for the pregnant woman to make an autonomous decision as to whether she wishes to undergo the treatment or procedure for her fetus' benefit. The pregnant woman is fully informed of the risks and benefits of the procedure

or treatment, along with alternatives to the recommended treatment or procedure, and the possible consequences of not undergoing the treatment or procedure.[268] There is also time for a fully informed ethical consent in which the hermeneutical stance of the maternal-fetal covenant relationship is explained in detail, along with normative theories from religious, legal, and philosophical viewpoints. The pregnant woman's beliefs and values should be discussed, along with her goals for the pregnancy.

There are times when some of the above examples may occur in an emergent situation such as umbilical cord prolapse with rupture of membranes or fetal distress. The moral norm of always obtaining informed consent allows for the exception of not obtaining informed consent in an emergency situation.[269] But competent patients have the right to accept or decline treatment, even in an emergency.[270] The result may be a situation of maternal-fetal conflict. When the pregnant woman declines treatment in an emergency situation, due to time constraints, ideally someone will be immediately available to present medical and ethical options to the pregnant woman in a quick, concise fashion in order to minimize potential harm to the fetus.

Communication is an important key in either an emergent or non-emergent situation of maternal-fetal conflict. Good communication can minimize conflict. The physician-patient relationship is strengthened and trust is established.

6.8 Conclusion

Contract does not provide a common normative approach or theory for resolving situations of maternal-fetal conflict. The pregnant woman, by not having an abortion when legally permissible, does not forfeit her liberty rights or ability to make autonomous decisions concerning her pregnancy by automatically entering into a contract with her

fetus to continue the pregnancy until birth. The courts cannot find the pregnant woman has breached a contract with her fetus if she does not undergo the cesarean section, resulting in harm to her fetus. The fetus, since it is unable to communicate with others in any manner, is unable to enter into a bilateral contract or agree to any terms or promises that are part of the contract. The fetus is also incapable of performing the obligations that result from contractual promises. Likewise, the fetus cannot decide to perform the acts spelled out in a unilateral contract.

The pregnant woman may decide to enter into a contractual agreement with her physician, spelling out the terms of her care and treatment during pregnancy. But she is not legally obligated to fulfill this contract either. Only if the pregnant woman believes she has a moral obligation to bring her fetus to a live birth will she be obligated to fulfill this contract. But moral obligation does not translate into a legal obligation for the courts.[271]

Like the legal, philosophical, religious, and professional medical organizations' normative approaches and theories, contract fails to provide a common normative approach to resolving maternal-fetal conflict. However, the pregnant woman can adopt a hermeneutical stance that gives depth of ethical meaning to her autonomous decision whether to have a cesarean section to save the life of or to prevent serious harm to her term viable fetus when her life is not endangered. The pregnant woman can clarify her autonomous moral decision by interpreting her developing relationship with her fetus throughout her pregnancy. Her autonomous decision should be consistent with her understanding of this relationship with her fetus.[272]

The hermeneutical stance can be based on the Judeo-Christian biblical covenant relationships. These relationships are either a unilateral covenant of promise or a bilateral covenant treaty in the Old Testament or Hebrew Bible between God and humans. The covenant relationship in the New Testament consists of discipleship with Jesus.[273] In all of these cases, the covenant relationship is a freely given gift of God to humans out of love for humans. God shows faithfulness and fidelity in these covenant relationships even when humans do not.

Like the biblical covenant relationships, the maternal-fetal covenant relationship is also a freely given gift of the pregnant woman to her fetus. The relationship is a gift as the pregnant woman has expected nothing in return from the fetus. She generously allows the fetus to grow and develop in her uterus throughout the pregnancy. The relationship reflects the pregnant woman's love for her fetus as charity or love of neighbor. Love of neighbor is a reflection of God's love for humans which makes possible humans love for each other.[274] Love of neighbor here is the pregnant woman's love of her fetus throughout the pregnancy. The maternal-fetal covenant relationship is based in faithfulness and fidelity as trust and loyalty. The pregnant woman is faithful to her fetus throughout the pregnancy, not taking any action to end the pregnancy. She is loyal to the fetus, showing care and concern by obtaining prenatal care throughout the pregnancy. She trusts that she has been doing the right things for the fetus throughout the pregnancy or at least not causing harm to the fetus.

The maternal-fetal covenant relationship can also be understood on a secular level as the above concepts and values are not exclusively religious and can be found, for example, in friendships and civil marriages. The maternal-fetal covenant relationship,

though sharing much with an ethic of care, goes beyond it as the ethic of care does not necessarily involve love. Care is not always enduring throughout the entire relationship. The hermeneutical stance can also be adopted to give a depth of ethical meaning to the pregnant woman's relationship with the various communities that she is a part of. The hermeneutical stance can be adopted regardless of one's views on the personhood of the fetus and is more than consenting to the maternal-fetal relationship.

The pregnant woman, based on her previous experience and expectations, may not initially interpret this developing relationship with her fetus throughout the pregnancy as a covenant relationship. But, after being presented with this concept, she may realize that a covenant relationship exists and choose to adopt this hermeneutical stance. Adoption of this hermeneutical stance should be consistent with her autonomous decision as to whether to undergo the cesarean section for her fetus' benefit. Having the cesarean section to prevent serious harm or death to her fetus when the pregnant woman's life is not endangered is consistent with this hermeneutical stance.

In the last chapter, I will discuss implications of adopting this hermeneutical stance to give depth of meaning to the pregnant woman's normative decision including possibilities for further research on maternal-fetal conflict.

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Chapter 7

Conclusion

7.1 Introduction

Maternal-fetal conflict refers to a perceived incompatibility between the pregnant woman's and fetus' interests. Maternal-fetal conflict can occur when a pregnant woman's obstetrician recommends a medical treatment, procedure, or surgery that she declines.[1] The health or the life of the fetus is threatened if the pregnant woman does not undergo the recommended medical treatment, procedure, or surgery.[2] In some situations the pregnant woman's health is also at risk. The question explored in this dissertation is: what is the pregnant woman's moral obligation to her fetus when faced with a situation of maternal-fetal conflict. There are many different situations of maternal-fetal conflict. The situation this dissertation focuses on is when a pregnant woman's obstetrician recommends a cesarean section to save the life of or prevent serious harm to her viable term fetus. The pregnant woman's life is not endangered. There is no additional risk to her beyond that of a routine cesarean section. Cesarean section, as discussed in chapter four, is increasingly accepted by obstetricians as an elective alternative to vaginal delivery on maternal request without a medical or obstetrical indication.[3]

Reasons why the pregnant woman may disagree with her physician's recommendation and decline the cesarean section include fear of surgery, fear of dying, religious beliefs, cultural reasons, and belief that the physician is wrong.[4] The pregnant woman may be pressured or receive conflicting information from other sources, such as her family, that influences her decision.[5]

7.2 Normative Theories and Approaches

Current legal, philosophical, professional medical organizations, and religious normative theories and approaches used to resolve situations of maternal-fetal conflict are inconsistent, as discussed in chapters two through five. The normative theories and approaches do not provide common ground for a plan of care that all involved parties can be comfortable with. Differences in beliefs and values among the involved parties can lead to conflict. Ultimately, the pregnant woman must decide whether to undergo the cesarean section for her fetus' benefit based on the available medical, legal, and ethical information despite the inconsistencies.

7.2a Legal

Whether the fetus is a person with rights protected under the United States Constitution must be considered when attempting to resolve a situation of maternal-fetal conflict from a legal perspective. The Supreme Court of the United States ruled in Roe v. Wade that the fetus is not a person as defined in the fourteenth amendment of the Constitution.[6] Therefore, the fetus does not have the same legal rights as the pregnant woman. However, the Supreme Court in Roe v. Wade also determined that states have an interest in protecting the life and health of the pregnant woman and the potential life of

the fetus.[7] The result is inconsistencies in court rulings in cases of forced cesarean section depending on the courts' interpretation of Roe v. Wade. The state's interest in protecting vulnerable life increases as the fetus grows and develops. Instructive on this point are cases where courts have found that a pregnant woman's liberty interest in decision-making must give way to the state's interest. In Jefferson v. Griffin Spalding County Hospital Authority and Pemberton v. Tallahassee Memorial Regional Medical Center, the courts ruled in favor of the state interest in protecting potential life, requiring the pregnant women to undergo the cesarean section. By contrast, in In Re A.C. and Baby Boy Doe v. Mother Doe, the courts upheld the pregnant women's right to refuse medical treatment.

Similar inconsistencies concerning the legal status of the fetus are also found in pregnancy clauses of advance directive laws. Thirty three states plus the District of Columbia limit a pregnant woman's advance directive in some manner. The state's interest in preserving the fetus' potential life takes precedence over the pregnant woman's right to determine her medical care and treatment. The fetus is also given status in state and federal fetal homicide laws and federal research laws. Under the federal Unborn Victims of Violence Act the fetus has the same status as the pregnant woman if killed.[8] Twenty five state fetal homicide laws do the same.[9] The other state fetal homicide laws vary as to the point in pregnancy that they apply. Federal research laws limit the amount of risk the fetus is exposed to when a pregnant woman participates in research.[10] The laws also require the father's consent in some cases.[11]

7.2b Philosophical

Inconsistencies exist when applying the philosophical theory of principlism to resolving situations of maternal-fetal conflict. The principle of respect for autonomy includes an individual's right to decide, based on the individual's own beliefs and views, whether to have a cesarean section.[12] Respecting another's autonomy means not interfering with the decision the individual has made. The principle is the same for pregnant and non-pregnant individuals.[13] The principle of justice requires individuals to be treated fairly. Justice requires pregnant and non-pregnant woman to have the same rights, including the right to accept and refuse medical care and treatment.[14]

Competing with respect for autonomy and justice are the principles of beneficence and nonmaleficence. Beneficence is defined as doing good for another and requires one to act positively for the benefit of others.[15] Specific beneficence, which is based on one's roles and relationships, is obligatory.[16] The pregnant woman's role as a parent to her future child is an example of specific beneficence. Doing good for her fetus obligates her to undergo the cesarean section to save the fetus' life or prevent serious harm to it.

Nonmaleficence is defined by Beauchamp and Childress as "an obligation not to inflict harm on others."[17] The negative obligation is thought to be stronger than beneficence. Nonmaleficence requires the pregnant woman not to harm her fetus. Refusing a cesarean section recommended for the fetus' benefit may cause harm to the fetus.

None of the four principles of biomedical ethics are absolute. When the principles conflict, as they may when applied to situations of maternal-fetal conflict, they must be

specified and balanced to determine which one is the moral obligation.[18] But specifying and balancing can lead to different conclusions for different individuals as to which principle should be followed. The process does not necessarily result in a consistent answer as to which principle is the pregnant woman's moral obligation.

Inconsistencies are also seen in philosophical duty theory. Many philosophers believe a pregnant woman has duties to her fetus based on the fact that the fetus is a future child with interests.[19] But disagreement exists as to the extent and limits of these moral obligations.[20] Some believe these duties should not go beyond the duties required of a parent to a child.[21] Courts do not require a parent to undergo surgery for the benefit of a child. Therefore, a pregnant woman should not be required to undergo a cesarean section for her fetus' benefit. All philosophers do not agree with this limit.

7.2c Professional Medical Organizations

Professional medical organizations, such as the American Medical Association and the American College of Obstetricians and Gynecologists, support respecting the pregnant woman's autonomy and the decisions she makes for her and her fetus with few rare exceptions. The organizations believe a pregnant woman should not be compelled to undergo medical treatment or surgery that she has refused. However, studies of obstetricians over the past couple of decades show some physicians favor beneficence towards the fetus.[22] The number of physicians favoring beneficence over respect for the pregnant woman's autonomy decreased over time. The studies are very limited and not representative of all obstetricians.

Many physicians view the pregnant woman and fetus as separate patients to whom they have separate obligations. The two-patient model is a result of technology

that allows the fetus to be visualized.[23] Also, there are medications and procedures that specifically treat fetal conditions in-utero. But the fetus can only be treated through the pregnant woman with her consent. Conflict can occur as the pregnant woman's and fetus' interests may not always converge. Contrasting with the two-patient view is the traditional view of treating the pregnant woman and her fetus as one patient. Harms and risks to the pregnant woman are balanced with benefits to the fetus.[24] Balancing benefits and harms to both is not possible with the two-patient model.

The change in the fetus' status as a patient and the increasing acceptance of cesarean section on maternal request as an elective procedure contribute to the inconsistencies seen between obstetricians' and professional medical organizations' views on maternal-fetal conflict.

7.2d Religious

Religions vary in their teachings concerning the status of the fetus and the resulting moral obligations to the fetus. Catholicism, Judaism, and Islam all teach that life is sacred and has dignity. Catholicism teaches that humans, from the moment of conception, are to be treated as a person with the same rights as a person.[25] Islam teaches that the fetus is a person whose life must be respected once ensoulment occurs at 120 days.[26] Judaism teaches that a fetus becomes a person at birth.[27]

Religions also vary in their teachings on autonomy and limitations to the pregnant woman's autonomy. Catholicism teaches that the pregnant woman must respect the rights of the fetus when making autonomous decisions for her and her fetus' medical care and treatment. Autonomy is limited in Islam by the physician's duty to heal. The physician makes decisions concerning medical care and treatment for the pregnant woman and her

fetus in Islam.[28] Autonomy in Judaism is limited by the halakhic duty to seek healing. However, limitations to autonomy vary among the different branches of Judaism. Reform Jews see autonomy as a primary guiding principle. Conservative Jews believe halakhah is primary, but do allow autonomy to be considered. Halakhah is primary for Orthodox Jews.[29] The different teachings on the status of the fetus and the pregnant woman's autonomy should be taken into consideration when attempting to resolve a situation of maternal-fetal conflict from religious moral viewpoints. Different moral obligations for the pregnant woman may emerge due to differences in religious teachings.

7.2e Summary

There is no consistent answer as to the pregnant woman's moral obligation to her fetus in this dissertation's situation of maternal-fetal conflict based on normative legal, philosophical, professional medical organizations, and religious theories and approaches. Unfortunately, this contributes to maternal-fetal conflict rather than resolving it. The lack of common ground is a result of different beliefs and values among those involved. These may come from more than one of the above theories and approaches. Unless one party can convince the other to change his or her values and beliefs, the conflict persists.

7.3 Hermeneutical Stance

Despite these inconsistencies, the legal and ethical normative theories and approaches are what are available to those involved in a situation of maternal-fetal conflict. But in addition to a normative approach, the pregnant woman can embrace a hermeneutical stance that gives depth of meaning to her autonomous decision.

Hermeneutics refers to the process of interpretation.[30] Hermeneutics in bioethics involves interpreting medical decisions or choices in the context of the individual's life narrative with particular meaning for the specific individual. The focus of interpretation by the pregnant woman is the developing maternal-fetal relationship from the beginning of the pregnancy up to the point of the maternal-fetal conflict. The pregnant woman can interpret the maternal-fetal relationship in a number of ways.

One interpretation is as a covenant relationship based on the Judeo-Christian biblical covenant relationships between God and humans. Similarities between the biblical covenant relationships and the maternal-fetal covenant relationship include both are a unilateral covenant, both are gifts, both are reflections of God's love for human, and both are based in faithfulness and fidelity. The pregnant woman's virtue is enlightened by adopting the hermeneutical stance. An autonomous decision by the pregnant woman to undergo the cesarean section is interpreted to yield depth of meaning by adopting a hermeneutical stance with regard to covenant relationship.

7.4 Limitations

There are limitations to this dissertation from both a normative and hermeneutical viewpoint.

7.4a Normative Limitations

One major limitation of this dissertation is it only considers one specific situation of maternal-fetal conflict and the resulting moral obligation of the pregnant woman. There are many other situations of maternal-fetal conflict. The situations will vary as to the degree of invasiveness and risks to the pregnant woman. They will also vary as to

whether the pregnant woman and/or the fetus will benefit from the procedure or treatment and the risks to one or both parties by not having the procedure or treatment. Alternatives to the proposed medical procedure or treatment may or may not be available. All of these factors determine what the pregnant woman's moral obligation is to her fetus in each individual situation based on normative theories and approaches. The pregnant woman's moral obligation to her fetus may change depending on the specific situation.

Another source of maternal-fetal conflict not considered here is behavior by the pregnant woman that potentially endangers her fetus. Examples of this are drug and alcohol use by the pregnant woman and exposure to toxic substances on the job or other places that can affect fertility or cause abnormalities in a developing fetus.

At issue in maternal substance abuse during pregnancy are the rights of the fetus and whether courts should prosecute pregnant women for injuring the fetus through the use of drugs or alcohol. The pregnant woman does not have a constitutional right to abuse illegal substances.[31] Courts have convicted and incarcerated pregnant women numerous times over the years for child abuse or child endangerment on these grounds.[32] An example is a 2004 case in Utah in which a 28 year old woman pregnant with twins declined a cesarean section for the fetuses' benefit. One child was stillborn and the other tested positive for cocaine. The woman was charged with first-degree murder and later pled guilty to two counts of child endangerment.[33]

The ethical issues involved with drug and alcohol abuse by pregnant women include screening and testing without consent and whether addiction should be criminalized versus treating it as a disease and not a moral or legal failure.[34] Punitive and coercive treatment of pregnant substance abusers damages the physician-patient

relationship and trust and may drive the pregnant woman away from the medical system. Providing adequate substance abuse treatment is believed to result in a better outcome for the pregnant and her fetus.[35] Normative theories and approaches used to resolve the conflict are the same as discussed in this dissertation. Individual beliefs and views differ as to the pregnant woman's moral obligation to her fetus and the legal obligation of the state.

The conflict present in workplace exposure is protecting the fetus or even children not yet conceived from hazardous substances that women are exposed to in the work environment versus women's equal rights to employment. An example of a hazardous substance that causes miscarriage, stillbirth, intrauterine growth retardation, and neurological disorders is lead.[36]

Companies and courts establish policies and laws based on their right to protect the fetus from injury.[37] Normative theories and approaches to support these policies and laws are nonmaleficence, beneficence, duties toward the fetus, and the state's interest in protecting the fetus. Women argue from the standpoint of equal rights to employment, job discrimination, and their rights to decide what is best for themselves and their fetuses or future children.[38] Normative theories and approaches applied here are the pregnant women's liberty rights, justice, and autonomy. The pregnant woman's moral obligation to her fetus in these types of situations can vary depending on the involved parties beliefs and values.

7.4b Hermeneutical Limitations

An additional limitation of the dissertation is only one hermeneutical stance is discussed. Interpreting the maternal-fetal relationship based on Judeo-Christian biblical

covenant relationships or the secular version of covenant relationship is but one understanding of the maternal-fetal relationship. Each pregnant woman has her own pre-understanding of pregnancy and the maternal-fetal relationship. Each pregnant woman will interpret her particular relationship with her fetus differently. Each pregnant woman will also be presented with other knowledge of pregnancy and the maternal-fetal relationship that can shape her interpretation. The additional knowledge and understanding will vary also. The result is many different interpretations of the maternal-fetal relationship. Examples include mothering as care, a detached perspective, or a strictly biological relationship of providing an environment for the fetus to grow and develop.

The hermeneutical stance of physicians and others involved in maternal-fetal conflict is also not explored. Each of these individuals has their own understanding and interpretation of the maternal-fetal relationship and pregnancy. Examples include a parental relationship and a caretaker or guardian relationship. These hermeneutical stances may not be the same as the pregnant woman's.

7.4c Summary

Because of the limitations to normative and hermeneutical perspectives discussed in this dissertation the conclusions reached here may not necessarily apply to other situations of maternal-fetal conflict. An example of this is when a pregnant woman's obstetrician recommends a cesarean section solely to prevent serious harm or death of her fetus. However, there is an increased risk of harm to the pregnant woman from undergoing the cesarean section. The same increased risk is not present with a vaginal delivery. The vaginal delivery is definitely safer for the pregnant woman. A pregnant

woman who has had multiple previous surgeries, infections, or other conditions that cause severe intra-abdominal adhesions, putting the pregnant woman at higher risk for bleeding or damage to her bowel, bladder, or other abdominal or pelvic organs fits this type of situation.

How the pregnant woman and others involved in her care view her moral obligation to her fetus may vary from situations where there is no increased risk to the pregnant woman. Each unique situation of maternal-fetal conflict needs to be examined. Risks and benefits to the fetus and pregnant woman differ in each situation, influencing the application and interpretation of the normative theories and approaches used to resolve maternal-fetal conflict.

7.5 Implications

The dissertation has implications for policy development in health care institutions, states, and professional medical organizations. Other implications include illuminating further research needed concerning different aspects of maternal-fetal conflict and education of physicians and health care staff about maternal-fetal conflict.

7.5a Policy

Physicians and health care institutions looking to the courts to resolve maternal-fetal conflict is not ideal. One way to prevent or minimize this is for health care institutions to adopt policy that addresses situations of maternal-fetal conflict. The medical ethics committee can develop the policy with the help of patients and the institution's obstetrics, legal, and administration departments. All health care institutions that do obstetrics should have a policy on maternal-fetal conflict. All physicians and staff

who care for pregnant woman, along with administrators, need to be familiar with the policy. A core group of physicians, ethicists, nurses, and administrators who are trained in implementing the policy and guiding others through situations of maternal-fetal conflict is vital. Without them, the policy may not be properly implemented or even ignored. The availability of ethics consultation to assist in resolving maternal-fetal conflict should be included as part of the policy.

Health care institutions' policies may also include preventive measures such as discussion of values and beliefs between physicians and patients early in pregnancy. Religious institutions should inform patients and physicians of policies limiting autonomous decision-making during pregnancy. Knowledge of potential conflicting values and beliefs allows these to be resolved or patients to transfer to another institution or physician. Knowledge of individual physicians' and staff's beliefs concerning maternal-fetal conflict can facilitate transfer of care, especially in emergency situations.

Some state policy on maternal-fetal conflict already exists in advance directive laws concerning pregnancy. Ethicists, patients, and physicians can assist in the development of additional state policy. But the result may be different laws in different states as seen with the advance directive laws. Laws may be challenged in the court system by those who disagree with them. For example, a law requiring a pregnant woman at term to undergo surgery solely for her fetus' benefit may be challenged based on the liberty rights of the pregnant woman. State policy may be controversial due to the inconsistencies in legal and ethical normative approaches and theories concerning maternal-fetal conflict. Legislators will vary in their personal beliefs. Court rulings do not

provide clear guidelines for states to follow. Whether policy can actually be successfully developed and implemented will not be known until states attempt to do so.

Professional medical organizations can further develop their current guidelines, opinions, and policies on maternal-fetal conflict. These documents can help guide physicians in practice and health care institutions in developing policy. Vagueness in guidelines for turning to the courts to resolve conflict needs to be removed. Although every single situation cannot be anticipated or addressed, more concrete examples and guidance eliminates ambiguity of interpretation. The documents do need to acknowledge the different values and beliefs of physicians. Guidelines for transferring care to another physician or institution is one way to address these differences. The documents should also acknowledge the inconsistencies in normative theories and approaches. All the organizations should promote ethics consults and the development of health care institutional policies to assist in resolving situations of maternal-fetal conflicts.

7.5b Research

The incidence of maternal-fetal conflict needs further study as it is unknown. As discussed in chapter four, the three United States studies were limited as to the population surveyed. The studies were also limited as they did not explore the reasons behind the physicians' answers. The studies did not survey general obstetricians in clinics, private practice, and academic settings or maternal-fetal medicine specialists in private practice. Nor did they examine the incidence of maternal-fetal conflict that was resolved outside of the court system, such as the pregnant woman avoiding physicians and hospitals or being coerced into undergoing an unwanted treatment or procedure. Studies of a more representative sample of obstetricians in all areas of the United States and all types of

obstetrical practice should be done to determine a truer picture of the incidence of maternal-fetal conflict. Situations in which judicial intervention was not sought should be included. More in-depth studies of reasons for physicians' views concerning maternal-fetal conflict are needed. These can be similar to the European study by Cuttini, et. al.

Research can be done to assess the effectiveness of preventive measures in decreasing maternal-fetal conflict. All of the research can guide health care institutions' and professional medical organizations' policies, along with education efforts.

Additional research can be conducted on the hermeneutical stance. Pregnant women's understanding of covenant relationship and how receptive they are to interpreting the maternal-fetal relationship as a covenant relationship can be studied. Pre-understanding of pregnancy and the maternal-fetal relationship can be examined. Research to discover if pregnant women are aware of how they understand and interpret their developing relationship with their fetuses would be valuable. Whether reflecting on their understanding of the maternal-fetal relationship changes it at all is can also be explored.

Another area to research is different approaches to hermeneutics. For example, dialogical hermeneutics involves the reciprocity of all parties in a manner that all are parties are open to each other and receptive to change.[39] Widdershoven points out patients are expected to do this by health care professionals. Health care professionals are not as open to change based on the patient's perspective.[40] But hermeneutic dialogue and understanding requires being open to other's perspectives. So does an effective informed consent process and negotiations with patients. Both health care providers and patients being open to persuasion by the other is the hermeneutical point of view.[41]

The hermeneutical point of view can be explored with obstetricians, hospital staff, and patients. How open and receptive physicians and staff are to patients' understanding and interpretation of pregnancy and the maternal-fetal relationship can be studied. Studies can also look at what variables contribute to increased openness to patients' perspectives. Finally, the effect this has on the incidence of maternal-fetal conflict can be examined. If maternal-fetal conflict decreases, educational tools can be developed and studied to find the ones that lead to greater openness to patient perspectives.

7.5c Education

Education of physicians, hospital staff, and administration is crucial for decreasing maternal-fetal conflict. There are different components to a successful education program. One component is teaching communication skills. Effective communication is vital to all interactions with patients. Discussion of risks, benefits, alternative treatments, and no treatment, along with patients' values, beliefs, and expectations is essential for autonomous decision-making by patients. Effective communication increases trust, addresses patient fears, provides valuable information for all involved, and strengthens the physician-patient relationship.

Educating physicians and staff to identify potential sources of maternal-fetal conflict early in pregnancy is also important. Issues can be discussed with patients and treatment plans developed. Training physicians and staff to proactively address issues to avert conflict rather than reacting to it after it occurs will hopefully decrease the incidence of conflict. Patients also have time to transfer to a physician or institution that will honor their autonomous decisions.

Another important component is educating physicians, staff, and/or ethics consultants in conflict resolution techniques. Making physicians, staff, and patients aware of the availability of ethics consults is also valuable. Both of these methods can help resolve situations of maternal-fetal conflict.

Ethics education of physicians and staff as to the different legal, philosophical, religious, and professional medical organizations normative approaches and theories is vital. Pointing out the inconsistencies in these theories and approaches illustrates for the physicians and staff why maternal-fetal conflict occurs. Helping staff and physicians to explore their own beliefs and values concerning maternal-fetal conflict is also important so that they can understand the biases they bring to these situations.

Hermeneutical theory can also be taught. Physicians and staff can explore their own understandings and perspectives of pregnancy, maternal-fetal relationships, and physician-patient relationships. How these may differ from patients' interpretation can be taught. As discussed previously, physicians and staff can also be taught the importance of being more open and receptive to patients' perspectives and the most effective ways to learn how to accomplish this.

7.5d Summary

There is policy, research, and education implications suggested by this dissertation that can be explored and developed to further resolution of situations of maternal-fetal conflict and help navigate the inconsistencies of the normative theories and approaches. Studies of hermeneutical stances can also further understanding of the different perspectives of patients, physicians, and hospital staff.

7.6 Conclusion

As this dissertation shows, inconsistencies exist within and between legal, philosophical, religious, and professional medical organizations normative theories and approaches on resolving maternal-fetal conflict. Common ground for all involved parties to agree on does not exist due to the differing values and beliefs. There is no consistent answer as to what the pregnant woman's moral obligation is to her fetus when a cesarean section is recommended to save the life of or prevent serious harm to her fetus. The pregnant woman's life is not endangered and there is no additional risk beyond that of a routine cesarean section. The pregnant woman's moral obligation to her fetus will vary depending on the normative theory or approach.

The pregnant woman can adopt a hermeneutical stance to give ethical meaning to her autonomous decision. The hermeneutical stance explored here is interpreting the maternal-fetal relationship as a covenant relationship based on Judeo-Christian biblical covenant relationships between God and humans. Interpreting the maternal-fetal relationship as a covenant relationship gives meaning to her autonomous decision to undergo the cesarean section.

Preventive measures to decrease the incidence of maternal-fetal conflict are very important given the lack of common normative ground to resolve conflict. Courts and state laws may only escalate the conflict and damage the physician-patient relationship. Education of physicians, hospital staff, and patients and the development of health care institutional policies may be the most effective means of decreasing maternal-fetal conflict. Research to better delineate the sources and incidence of maternal-fetal conflict, along with identifying the most effective educational tools are needed to guide these

efforts. Ethics consultation should always be available to help resolve situations of maternal-fetal conflict.

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