THE PROFESSIONAL RESPONSIBILITY MODEL OF OBSTETRIC ETHICS: AVOIDING THE PERILS OF CLASHING RIGHTS

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Condensation

The obstetrical community should adopt the professional responsibility model of obstetric ethics and abandon conceptually and clinically inadequate rights-based models.

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Abstract

Obstetric ethics is sometimes represented by polarized views. One extreme asserts the rights of the rights of the fetus as the overwhelming ethical consideration. Another extreme asserts the pregnant woman as the overwhelming ethical consideration. Both assertions are overly simplistic. Such oversimplification is called reductionism. This paper explains the fallacy of rights-based reductionism and two models of obstetric ethics based on it and explains why the fetal rights reductionism model and the pregnant woman's rights reductionism model result in conceptual and clinical failure and therefore should be abandoned. The paper argues for the professional responsibility model of obstetric ethics, which emphasizes the importance of medical science and compassionate clinical care of both the pregnant and fetal patient. The result is that responsible medical care overrides the extremes of clashing rights.

Key Words

Beneficence, ethical reductionism, fetus as a patient, professional responsibility, respect for autonomy, patients' rights

INTRODUCTION

Every obstetrician is challenged by the clashing demands of fetal rights versus maternal rights.[1-4] Their resulting polarization forces the obstetrician into the unwelcome role of Odysseus struggling to avoid the mythical sea monsters of Scylla and Charybdis, either one which could devour his ship and crew if he sailed too close. To starboard, stand, like Scylla, the exclusive assertions of the rights of the fetus.[5] To port, stand, just as unyielding, stand Charybdis, the exclusive assertions of the rights of the pregnant woman. Ethical peril awaits the obstetrician who sails too close to either extreme of rights, just as deadly peril did for Odysseus and his crew.

Models of obstetric ethics based on rights-based extremes commit the fallacy of rights-based reductionism. The purposes of this paper are to explain the fallacy of rights-based ethical reductionism and two models of obstetric ethics based on it, explain why these models of rights-based reductionism are not acceptable, and put forward an ethically justified and clinically applicable alternative, the professional responsibility model. The professional responsibility model equips the obstetrician to successfully navigate the perils of rights-based Scylla and Charybdis by focusing on professional responsibility to and for patients. Just as Odysseus bore the responsibility to protect his crew, the obstetrician bears the responsibility to protect both the pregnant and fetal patient.

THE FALLACY OF RIGHTS-BASED REDUCTIONISM

The fallacy of rights-based reductionism can be understood by analogy to the fallacy of biological reductionism or oversimplification of scientific models of disease and health. As an antidote to biological reductionism in medicine, George Engel made a sentinel contribution with his introduction of the biopsychosocial concept of health and disease.[6-9] In his classic paper in *Science* Engel summarized the biomedical model:

> The dominant model of disease is biomedical, with molecular biology its basic scientific discipline. It assumes disease to be fully accounted for by deviations from the norm of measurable biological (somatic) variables. It leaves no room within its framework for the social, psychological, and behavioral dimensions of illness. ... the biomedical model embraces both reductionism, the philosophic view that complex phenomena are ultimately derived from a single primary principle, and mind-body dualism, the doctrine that separates the mental from the somatic. Here the reductionist primary principle is physicalistic; that is, it assumes that the language of chemistry and physics will ultimately suffice to explain biologic phenomena.[7, pp. 39-40]

The history of biological reductionism stands in contrast to traditional Chinese medicine, based on the concept of *qi*, which was understood to have both physical and spiritual components in an "incessant process of transformation."[10] This history also

stands in contrast to more holistic strands in the history of Western medicine, e.g., naturopathy and homeopathy. Here we sketch a complicated history.[11]

Ancient Hippocratic physicians understood all diseases to be an interaction of the four humors. According to the Hippocratic or Coan school of medicine, diseases resulted from imbalances among blood, phlegm, black bile, and yellow bile. This theory recognized the existence of environmental factors, such as prevailing wind direction, but the explanation of the direct causes of disease and of their subsequent clinical management, mainly by modest changes in diet and exercise and the use of mild medications, appealed to what they took to be the biologically fundamental realities, the humors. Later anatomy became fundamental and the focus shifted to the skeleton and organs as the seat of diseases. Debates arose about more aggressive or "heroic" treatment, especially surgery, to correct abnormal anatomy. Physiology, the science of the functions of organs and then organ systems, then displaced anatomy as fundamental. Medications and potions to correct symptoms of abnormal function became increasingly important. The discovery of microbes led to a dramatic conceptual shift. The seat of disease was now understood to be microscopic, which led to an increased understanding of the pathophysiology and treatment of infections. We are now well into the era of genomic medicine, in which the genome supersedes the microbe as a senior partner in explaining the biological basis of health and disease.

Engel's concern was that equating health and disease with biological fundamentals commits physicians to a clinically inadequate model of health and disease that results in inadequate diagnosis, prevention, and treatment. For example, a married

woman of child-bearing years presents with a complaint of infertility. The biomedical model focuses on the mechanisms of ovarian, tubal, uterine, and sperm function. The biopsychosocial model includes this focus but rejects it as the exclusive focus, because it is clinically incomplete and could result in unneeded, invasive, and expensive work-up and assisted reproduction. A psychosocial assessment goes on to identify psychological and social factors such as stress in the workplace or household, which would be elicited only by a more complete history and would be missed by a work-up for impaired anatomy of reproduction. The biopsychosocial model is clinically crucial because it reminds the obstetrician that psychosocial, as well as anatomic and pathophysiologic factors can result in reproductive failure.

As this example illustrates, Engel's concern was not the limitations of our scientific knowledge at any given time about what is assumed biologically fundamental in obstetrics. His point was that even a very sophisticated scientific fund of knowledge about, for example, human reproduction, will be scientifically and therefore clinically fallacious if it focuses only on the biological aspects of health and disease, e.g., the basic science mechanisms of reproduction, mistaking these mechanisms of disease for an adequate model of the totality of the disease. Incorporating the psychological and social dimensions is required to have a clinically adequate model to guide obstetric care and thereby avoid clinical tunnel vision. Fulfilling the requirements of the biomedical model by finding an anatomic cause for infertility, may be very fulfilling for the physician on a narrowly scientific basis, but not for the patient, whose complaint will remain inadequately addressed if her infertility is also a function of unidentified and therefore unmanaged psychosocial factors.

Engel's main point remains germane: the biomedical model is becomes a fallacy when it is assumed to be complete. The remedy is to recognize that it is scientifically and clinically incomplete and misleading. Comprehensive clinical judgment requires attention to the clinically relevant biomedical *and* the clinically relevant psychosocial aspects of pregnancy.

There is an analogous fallacious reductionism in obstetric ethics. The phrase, "ethical reductionism," has been used,[12] but not in a way that makes this analogy explicit. The fallacy of ethical reductionism occurs when a model for ethics appeals to one ethical concept in complex clinical circumstances that by their very nature require consideration of complementary concepts. Rights-based reductionism in obstetric ethics bases it exclusively on the rights of either the pregnant woman or the fetus and ignore other clinically relevant ethical concepts. (Table 1)

The fallacy of right-based reductionism shapes the current abortion controversy. Consider first the model of obstetric ethics based on unconditional fetal rights, especially the right to life. The logic of this concept means that fetal rights always override the rights of the pregnant woman. Termination of pregnancy at any gestational age or for any reason is therefore impermissible, regardless of whether the pregnancy is voluntary or not. Consider, next, the concept of the woman's unconditional rights, especially the right to control her body. The logic of this concept means that the pregnant woman's rights always override fetal rights. Termination of pregnancy is therefore permissible at any gestational age.[13] (Table 1)

Rights-talk has an undeniable appeal, because rights-talk seems so clear-cut: one either has rights or one does not and, if one does, others must respect one's rights. This is a false veneer of certainty masking the fact that there is significant controversy about the nature and limits of fetal and maternal rights. Debating rights results in intractable disputes, since rights are based on so many factors, including cultural, political, and religious beliefs that do not lend themselves to compromise and are peripheral to the physician-patient relationship.

It is obvious that a pregnant woman has rights, including an unconditional right to control what happens to her body. There is enormous dispute about whether that right should be understood to come with limits or with no exceptions throughout the entire pregnancy. Professional integrity, for example, sets justified limits on the preferences of pregnant women.[14,15]

Claims that the fetus has rights, especially an unconditional right to life, are in endless dispute. Some take the view that the fetus has no rights while others assert strong rights of the fetus. Those who assert that the fetus has rights must – but often in fact do not – recognize that the world's religions and their moral theologies are not in agreement.[16-20] Nor are philosophers.[13] Indeed, there is no single authoritative perspective from which the incompatible differences of these diverse views on fetal rights can be resolved.[21] Such an authoritative source would have to be acceptable to all of the competing accounts and conceptual frameworks. This is not achievable because of an unavoidable fact. There is profound and irresolvable disagreement

between different religious and cultural traditions, within such traditions, and between religious and secular views on fetal rights.

The pregnant woman's rights reductionism model appears in the literature on intrapartum management. This model asserts the unconditional right of the pregnant woman to control her body and the implicit position that the fetus has no rights. The pregnant woman has rights and her rights control performance of cesarean delivery: " ... the moral and legal primacy of the competent, informed pregnant woman in decision making is overwhelming."[22, p. 1213] A recent expression of this model takes what at first seems a non-reductionist approach. Its authors acknowledge patient safety as a "first-order issue"[23, p. 341] and support what they call "restrictive guidelines" based on protecting the life and health of pregnant women.[23] However, they abandon this more nuanced approach in favor of an exclusive emphasis on the pregnant woman's rights reductionism model when they assert: "Crucially, even when restrictive guidelines are warranted the rights of pregnant women to bodily integrity must be maintained."[23, p. 343] Some express the model in explicit terms, e.g., that "women have fully endowed rights that do not diminish with conception, nor progressively degrade as pregnancy advances to viability and birth."[24, p. 318] Another example is the assertion of the pregnant woman's autonomy as an "unrestricted negative right," i.e., an unconditional right to non-interference with refusal of cesarean delivery: "autonomy is an inter-relational right – ultimately there is no circumstance in which someone should be brought to an operating room against their will."[25] The pregnant woman's rights reductionism model also grounds claims to the rights of pregnant women to have a clinically non-indicated cesarean delivery.[26-28]

Rights-based reductionism models invite the unwary obstetrician to be satisfied with an oversimplified solution: deciding whose rights win out in a zero-sum game – those of the pregnant woman or those of the fetus. This solution, however it might appeal to us in its simplicity, is ethically and clinically inadequate. Rights-based reductionism in obstetric ethics is a fallacy.

THE PROFESSIONAL RESPONSIBILITY MODEL OF OBSTETRICS ETHICS

Because they are fallacious, rights-based reductionism models distort the fundamental nature of the relationship of a physician to his or her patients, a relationship of professional ethical obligations. (Table 1) The professional obligations of the obstetrician-gynecologist originate in the ethical concept of medicine as a profession. This concept was introduced into the history of medicine by two remarkable British physician-ethicists: John Gregory (1724-1773) of Scotland and Thomas Percival (1740-1804) of England. This concept requires the physician to make three commitments: (1) becoming and remaining scientifically, ethically, and clinically competent; (2) protecting and promoting the health-related and other interests of the patient as the primary concern and motivation; and (3) preserving and strengthening medicine as what Percival called a "public trust," a social institution that exists primarily for the benefit of society not its members (in contrast to the concept of medicine as a merchant guild).[29] The ethical concept of medicine as a profession makes assumption of fiduciary responsibility the defining feature of the physician-patient relationship. In

the professional responsibility model obstetricians have ethical obligations to both the pregnant and fetal patient.[21,30]

There are two views on the health-related interests of the patient, both of which must be taken into account.[21] The first perspective, which is dismissed by fallacious rights-based reductionism, is clinical. This clinical view is shaped by evidence-based clinical judgment about diagnostic and therapeutic measures that are reliably expected to result in a greater balance of clinical goods over clinical harms, understood in biopsychosocial terms. This perspective is expressed by the principle of beneficence.[21,31] The second perspective is the patient's, shaped by her evidence-based *and other* judgments about which diagnostic and therapeutic interventions are expected to result in a greater balance of clinical benefits over harms. This view is expressed by the principle of respect for autonomy.[19,31] Respect for the autonomy of the pregnant woman who is a patient requires more than acknowledging and implementing rights. Respect for autonomy should also be understood in biopsychosocial terms: the physician should acknowledge and respect the integrity of the patient's values and beliefs, especially those that she has for her pregnancy. An individual's values and beliefs are drawn from multiple social sources, including one's family upbringing, culture, and religion. These psychosocial sources of a patient's values and beliefs should always be acknowledged and respected. Showing such respect helps to promote a sense of psychological safety and security that contribute significantly to a strong physician-patient relationship. Patients use their values and beliefs to assess the medically reasonable alternatives that are offered or recommended to them in the informed consent process, which should be used to

support the very important psychosocial values of trust and respect. The obstetrician has both beneficence-based and autonomy-based obligations to the pregnant woman. (Table 1)

The ethical concept of a human being becoming a patient is based on the principle of beneficence and has two components. The human being is presented to a physician and there exist clinical interventions that are reliably expected to clinically benefit that human being.[21] A pregnant woman becomes a patient when she is presented for obstetrical care. A fetus becomes a patient in a more complex fashion. We have argued elsewhere that the viable fetus becomes a patient when the pregnant woman is presented for obstetrical care.[21] The obstetrician has beneficence-based obligations to the viable fetal patient. (Table 1) We have also argued elsewhere that the pre-viable fetus becomes a patient when the pregnant woman is presented for obstetrical care and the pregnant woman confers the moral status of being a patient on her fetus, on the basis of her own values and beliefs.[21] When the pregnant confers the status of patienthood on her fetus, the obstetrician has beneficence-based obligations to it as a fetal patient. When she does not do so, no beneficence-based obligations to the fetus exist. (Table 1)

Obstetricians can be certain when they have a professional relationship with a patient and therefore responsibility to and for that patient: the pregnant woman or fetus is presented to the obstetrician-gynecologist and there exist clinical interventions that reliable expected to benefit the patient clinically. Both of these criteria for when a human being becomes a patient are easy to apply clinically and universally applicable.[21]

The fallacy of rights-based reductionism models is that they only *appear* to be easy to apply clinically and to be universally applicable. Their apparent robustness creates a veneer of certainty that, when subject to critical scrutiny, collapses. Consider first the fetal rights reductionism model. Having rights is a function of the clinical reality of having autonomy. In the most rigorous accounts of it having autonomy is achieved only when an individual is capable of valuing himself or herself without regard to the moral judgments of others.[32] This complex , very cognitively demanding self-awareness and judgment require at the very least self-consciousness and social interaction. The biological fact is that at all gestational ages the immature developmental status of the fetus's central nervous system and its location in utero is such that it cannot yet support the complexity of psychosocial activity that generates autonomy as a clinical reality. This outcome is not a problem for the professional responsibility model, because the ethical concept of the fetus as a patient makes no reference to the autonomy of the fetus and therefore no reference to fetal rights. The fetal rights reductionism model, despite its simplicity and powerful initial appeal, is fallacious because it leads obstetric ethics into conceptual and clinical failure. This model therefore should be abandoned.

Consider next the pregnant woman's rights reductionism model. This model requires the obstetrician to implement birth plans that unconditionally exclude cesarean delivery or the unconditional right to planned home birth. This model eliminates the obstetrician's beneficence-based obligations to *both* the pregnant and fetal patients and therefore reduces the obstetrician to a mere automaton. This model also has absurd implications, e.g., ruling out as potential paternalism strongly and repeatedly recommending that pregnant women who abuse tobacco and alcohol seek help and be

supported in doing so. Respect for the pregnant woman's rights allows simply accepting such clinically choices by patients because they have made clinically unwise, but autonomous, choices. This is abandonment from the perspective of professional responsibility for patients. The pregnant woman's rights reductionism model, despite its simplicity and powerful appeal for many, is fallacious because it leads obstetric ethics to conceptual and clinical failure. This model therefore also should be abandoned.

CONCLUSION

The Scylla and Charybdis of rights-based reductionism models should be abandoned and replaced by the professional responsibility model. By basing obstetric practice on the professional responsibility model of obstetric ethics, the obstetrician creates a solid foundation for the care of the pregnant and fetal patient: the physician-patient relationship as a professional commitment.

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Table 1: Three Models of Obstetric Ethics

	Fetal Rights Reductionism Model	Professional Responsibility Model	Pregnant Woman's Rights Reductionism Model
Pregnant Woman	Pregnant woman's rights systematically secondary to fetal rights	Autonomy-based and beneficence obligations	Pregnant woman's rights systematically override fetal rights
Pre-viable Fetus	Fetal rights systematically override woman's rights	Beneficence-based obligations, if the status of patienthood is determined by the pregnant woman	Fetal rights systematically secondary to woman's rights
Viable Fetus	Fetal rights systematically override woman's rights	Beneficence-based obligations	Fetal rights systematically secondary to woman's rights