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Rodrigues, H. Catarina M. L.; van den Berg, Paul P.; Duwell, Marcus

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PAPER

Dotting the I's and crossing the T's: autonomy and/or beneficence? The 'fetus as a patient' in maternal–fetal surgery

H Catarina M L Rodrigues,¹ Paul P van den Berg,¹ Marcus Düwell²

¹Department of Obstetrics and Gynaecology, UMCG, Groningen, Groningen, The Netherlands

²Department of Philosophy, Utrecht University, Utrecht, The Netherlands

Correspondence to

Catarina Rodrigues, Department of Obstetrics and Gynaecology, University Medical Center Groningen, Hanzeplein 1, postbus 30.001, 9700 RB Groningen, The Netherlands; catarina.rod@gmail.com

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ABSTRACT

Chervenak and McCullough, authors of the most acknowledged ethical framework for maternal–fetal surgery, rely on the 'ethical–obstetrical' concept of *the fetus as a patient* in order to determine what is morally owed to fetuses by both physicians and the women who gestate them in the context of prenatal surgery. In this article, we reconstruct the argumentative structure of their framework and present an internal criticism. *First*, we analyse the justificatory arguments put forward by the authors regarding the moral status of the fetus qua patient. *Second*, we discuss the internal coherence and consistency of the moral obligations those authors derive from that concept. We claim that some of the dilemmas their approach is purported to avoid, such as the debate about the independent moral status of the fetus, and the foundation of the moral obligations of pregnant women (towards the fetuses they gestate) are not, all things considered, avoided. Chervenak and McCullough construct the obligations of physicians as obligations towards entities with equal moral status. But, at the same time, they assume that the woman has an independent moral status while the moral status of the fetus is dependent on the decision of the woman to present it to a physician for care. According to the logic of their own argumentation, Chervenak and McCullough implicitly admit a different moral status of the woman and the fetus, which will lead to different ascription of duties of the physician than those they ascribed.

INTRODUCTION

Maternal–fetal surgery (MFS) can be defined as a series of prenatal surgical interventions which aim at correcting or improving the outcome of life-threatening or severely debilitating fetal congenital birth defects.

The century-old idea that pregnancy is an instance of conflict and that women and fetuses are potential antagonists are present throughout the literature on 'fetal surgery'. That discourse eventually led to the widespread idea that the fetus is a patient in its own right, separate or separable from the woman in whom it gestates.^{1 2} The 'fetal patient' gained its way into the vocabulary of 'fetal surgeons' who use it to justify the clinical and social value of their discipline and their own personal moral obligations towards the fetuses they operate on, almost as if it were an undisputable or self-evident truth.^{1 3 4}

In order to determine what is morally due to both fetuses and women in the context of MFS,

Chervenak and McCullough (C&M), authors of the most acknowledged ethical framework for MFS, also rely on what they call the ethical–obstetrical concept of 'the fetus as a patient'.^{5–7}

But that the fetus is or can become a patient in its own right is not self-evident at all. And, if it is going to be the foundation of the 'maternal' and of the clinicians' moral obligations towards the fetus, justificatory argument must be given. In this paper, we analyse the arguments put forward by C&M for the moral status of the fetus qua patient and we discuss whether the moral obligations those authors derive from that concept are internally consistent and coherent.

MORAL STATUS OF THE FETUS QUA PATIENT

To have moral status is roughly to be worth of moral concern and respect. There are many theories about how one comes to acquire it, but most justifications depend on the possession of a certain property or quality (being alive, sentient, a member of a certain species, being a person, a rational agent, having the potential to acquire or develop the relevant property, etc). It is just not possible within the scope of this paper to discuss the justification for the ascription of moral status in detail. Instead, we focus on the issues that arise when we try to apply a theory, like the one proposed by C&M, which grounds moral obligation towards the fetuses on their special social standing of being patients.

Dependent versus independent moral status

C&M have construed a beneficence-based concept of being a patient and have extended it to the debate of the moral status of the fetus.^{7–9} They distinguish between *two kinds of moral status*: that which is based on an entity's constitutive property/ies (*independent moral status*) and that which is the result of special social interactions, independently of one's constitutive properties (*dependent moral status*). Dependent moral status is acquired in virtue of an entity's position in relation to others and in the context of a particular relationship, namely, the one that is established between a patient and a physician.

Being a patient is thus to have a moral status of sorts. An entity becomes a patient and, for this reason, worth of moral consideration as such when it is presented to a physician for care and there are

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interventions that are reliably expected, from an evidence-based clinical point of view, to benefit it.⁷

On their account, it is the physician's commitment to fiduciary responsibility towards those presented to his/her care that is the basis for the ascription of the moral status of 'patient'. From this perspective, from the point of view of a physician, all patients are patients in the same degree, independently of any other qualifying properties. One does not need, for example, to be a person in any morally relevant sense of the word to be a patient. One needs only to be or be placed in a relationship that generates moral status and the correlative moral 'relation-generated' fiduciary obligations. Since there are no degrees of being a patient, the fiduciary benefice-based obligations of physicians towards their patients do not also vary in degree.⁷

The moral status of the 'pregnant and fetal patients'

C&M consider that there are at least two, albeit inseparable, patient-research subjects in MFS: a woman and at least one fetus. The moral status of such different but inseparable entities would differ in that average adult women have full, independent moral status, and fetuses may have dependent moral status. Pregnant women have independent moral status because they generally possess the characteristics or properties (eg, humanity, reason, personhood) that, according to most ethical theories, give them a claim to have their legitimate interests protected and eventually promoted and a right to have one's legitimate interests respected by others. In contrast, according to C&M, fetuses may have dependent moral status because even though they might lack the features necessary for independent moral status, their social position in relation to others is such that it generates moral status and correlative moral relation-generated obligations to protect that entity's interests, in this case, its clinical interests.⁷

The argument of C&M for the moral status of the fetus qua patient can be summarised in the following captions:

1. When the entity presented for care is a fetus, its being a patient is the function of: (a) its position in the relationship with a physician, (b) the existence of interventions that, from a medical point of view, are reliably expected to benefit it and (c) the existence of a reliable link between the fetus and its later achieving the moral status of a child, and then a person.
2. There are two links between the fetus and its later achieving the moral status of a child, and then a person: (a) the pregnant woman's choice to continue a previsibleⁱ pregnancy to term and (b) her choice to present her viable or previsible fetus to care by a physician.
3. When all the previous conditions are present, from the perspective of a physician, the previsible and viable fetus becomes worthy of moral consideration qua patient. For a physician that entails a prima facie beneficence-based obligation to protect its clinical interests. For the woman in whose body the fetal patient is gestating, fetal patienthood involves a similar ought. The difference between the moral obligations of physicians and pregnant women towards the fetal patient is determined only by viability, and only in relation to the pregnant women. That is, according to

C&M, pregnant women are under no moral obligation to present their previsible or viable fetuses to care by a physician, even when there are clinical interventions that might benefit them, or the children that they will become. When, however, a woman chooses to present a viableⁱⁱ fetus to care, this too originates a prima facie beneficence-based obligation to protect that fetus' clinical interests that cannot be waved. That is, according to C&M, both physicians and pregnant women have prima facie beneficence-based obligations towards the viable fetal patient.

4. In addition, because fetal and pregnant patients are different but inseparable patients, and because the moral status of pregnant women as patients is an independent one, physicians must in all cases balance prima facie beneficence-based obligations towards the fetus against prima facie beneficence- and autonomy-based obligations towards the woman in whose body the fetus gestates. Because fetuses are patients only through the autonomous choice of pregnant women, and since the latter have independent moral status, physicians must at all times, but not unconditionally, respect their autonomous choices.

Referral of C&M to four principles of biomedical ethics of Beauchamp and Childress: autonomy and beneficence

It is important to point out that the proposal of C&M is to build up from the perspective of physicians who take care of pregnant patients and specialise in interventions that aim at benefiting the fetus. In order to determine what is morally due to the fetal patient by those in charge of its care in the context of MFS, they refer to both John Gregory's work and the well known 'four principle' approach to biomedical ethics developed by Beauchamp and Childress.^{7 8 11} As guidance for practical moral decision-making, this approach puts forward the principles of respect for autonomy, of beneficence, of non-maleficence and of justice.

Beauchamp and Childress do not offer a comprehensive ethical theory but a kind of approach that should guide decision-making in a process of weighing and specifying the four principles. The status they ascribe to the four principles has changed over the last decades in the various versions of their book since its first publication in 1979. According to their current view, Beauchamp and Childress see the four principles as an expression of a so-called shared or universal common morality which contains all principles and only those principles that all morally serious persons accept as authoritative.¹² The principles are grounded in common morality in the sense that they are grounded in a sort of pretheoretical moral point of view to which everyone has access, that is not equivalent to any particular ethical theory and that transcends local customs and attitudes. For this reason, the four principles are not in a hierarchical position in relation to a higher ethical principle, like the greatest happiness principle in Utilitarianism or the categorical imperative for Kantians, and they are also not in a hierarchical position in relation to each other as action guiding norms. As Beauchamp and Childress, C&M also sustain the prima facie character of moral principles. That means that each principle is binding unless it conflicts with another, which, according to the circumstances of the case at

ⁱThe biological, medical and legal concept of fetal viability consists of the expected capacity of the fetus to survive birth, even if for that substantial technological support is needed. In most developed countries, a fetus is said to acquire this ability at 24 weeks of gestation.¹⁰

ⁱⁱA pregnant woman can confer and withdraw the moral status of patient to her fetuses at any time during previsibility, because there are no medical interventions that are reliably expected to benefit her fetus were it to be born before the gestational age of viability.

hand, is also pertinent. When the latter leads to an irreconcilable conflict of obligation, a solution that is compatible with the clashing principles must be found.ⁱⁱⁱ

If this is the background against which the ethical framework of C&M for MFS research should be understood, then there are several points that deserve further consideration.

Beneficence versus autonomy in MFS

First, there is the question of whether moral status, understood as being worth of moral consideration, is something that can be derived from an entity's position in a social relationship, like the one that is established between physicians and patients. In a reply to Carson Strong,¹⁴ C&M sustained that their theory about dependent moral status applies exclusively to a special group of entities, that is, human patients.¹⁵ By the same token, the moral obligations that derive from the moral status of fetuses as patients would be binding only to those who are morally engaged with them within a fiduciary relationship of medical care, and not extensive to all others who are worth of moral consideration on different grounds. One may also wonder why only human fetuses should have this dependent moral status, and not other entities. C&M do not offer a strong argument for this.

In addition, even if we assume that C&M provide a sufficient justification for the moral obligations of fetal surgeons towards the fetal patient, they do not provide sufficient justification of the moral obligations of pregnant women towards their fetuses in the context of MFS.

'A pregnant woman is obligated to take only reasonable risks of obstetric interventions that are reliably expected to benefit the viable fetus or child later'.^{16 iv}

However, because the connection between a woman and her fetus can hardly be described as a physician-patient relationship, the *prima facie* beneficence obligations C&M claim pregnant women have towards their fetuses must rely somewhere else. An account of the foundations of the moral obligations of pregnant women towards their fetuses is therefore missing.

Second, according to C&M, contrary to claims of independent moral status, 'the physician's commitment to fiduciary responsibility for the fetal and pregnant patient is a certain and therefore a highly reliable basis for the moral status of both patients'.¹⁵ In practice, what this means is that in the context of MFS there are two patients (albeit inseparable) to whom physicians owe role-specific beneficence-based obligations. Since, according to C&M, from a fetal surgeon's perspective, there are also no degrees of being a patient, their duty to provide

assistance and care to women and fetuses is not dependent on any other consideration, apart from their being patients.

In this sense, C&M defend an 'egalitarian' position in relation to the moral status of patients that produces beneficence role-specific obligations. In other words, as equals (in their role as patients) pregnant women and fetuses have an equal claim to receive available medical care that is reliably expected to medically benefit them. As a result, when a physician's duty of care to the pregnant women conflict with the duty of care he/or she owes to fetuses, a solution must be found that does not compromise the care of either those patients: a compromise that would consist on a violation of the role-specific moral obligations of physicians.

Third, that pregnant women carrying fetal patients are also fetal surgeons' patients in the same degree as fetuses is not self-evident, however. As previously mentioned, MFS is typically defined as a series of interventions that aim at benefiting the fetus and eventually the child and person it will become, by correcting or improving the outcome of congenital birth defects. If this is correct, one could indeed ask, who exactly the patient in MFS is. If an entity acquires the moral status of patient when it is presented to a physician for care and there exists interventions that are reliably expected to benefit it, then fetal surgery is not an intervention that can benefit directly the pregnant woman. Only if we take the effects of the fetal surgery on the psychosocial benefits for the pregnant woman into account this would make some sense, but that seems not to be the primary aim of the surgeons' interventions.

One of us has argued elsewhere that in the context of clinical research involving MFS, namely in the context of clinical trials comparing experimental fetal intervention with expectant management during pregnancy, pregnant women can be seen as volunteers of sorts, precisely because, for them personally, prenatal surgery has no prospect of direct benefit.¹⁷ These considerations were made in a different context but an analogy can be made here.

Credit must be given to C&M in this respect. They have actually claimed that because fetal patients are different but not separable from pregnant women, physicians must in all cases balance *prima facie* beneficence-based obligations towards the fetus against *prima facie* beneficence- and autonomy-based obligations towards the woman in whose body the fetus is gestating. Respect for the autonomy of a pregnant woman, translated into her choice of presenting a pre-viable or viable fetus for care, is justified by appeal to the latter's possession of independent moral status *qua* person and rights bearer.

What this means is that, in her relationship with fetal surgeons, the pregnant woman is a 'different' kind of patient than the fetus. Even though she has no prospect of direct clinical benefit from the fetal intervention, she has, apart from beneficence role-related claims, a claim (if not even a right) to have her autonomy respected by fetal surgeons. In other words, contrary to the fetus which has only beneficence-based interests that must be protected and fostered, pregnant women have additional morally justified claims in relation to fetal surgeons. The latter might entail that pregnant women and fetuses do not possess moral status as patients in the same degree, not even from a physician's perspective. If a pregnant woman is free, in virtue of her autonomy, to give and withdraw her moral status as patient, as well as the moral status of her pre-viable fetus, then, in relation to that fetus and in the context of the interaction with healthcare professionals, she assumes a privileged and superior status. In fact, her position is so privileged that the whole issue of fetal patienthood is dependent on her presenting

ⁱⁱⁱIn order to determine which principle/s should guide our actions in a particular context, the content of the four principles must be specified and justified in accordance with the circumstances of the case at hand. When the case at hand falls under the 'jurisdiction' of two or more principles, and when the application of both leads to an irreconcilable conflict of obligation, Beauchamp and Childress propose the use of the 'Rawlsian'¹³ inspired method of wide reflective equilibrium. Roughly, according to this method, the strengths and weaknesses of all plausible moral beliefs, moral judgments, principles, and moral theories are evaluated with the aim of finding a plausible and coherent solution to that conflict. A coherent solution to a conflict is the one that is most compatible with our most basic 'considered judgments', that is, with those beliefs and norms that all morally serious persons accept as authoritative and that translate into the four principles of biomedical ethics.

^{iv}We are aware of the controversial nature of this claim.¹⁵ However, as mentioned previously in this article, we will proceed without questioning it.

her fetus to a physician for care and, on her consenting, on a second moment to surgery for fetal benefit.

Conflict of obligation

A conflict of obligation for fetal surgeons will arise when on a first moment a pregnant woman confers the moral status as patient to her viable fetus by presenting herself and her fetus for medical care, and then, on a second moment, withdraws that status by refusing to submit herself (with her fetus) to surgery.

In these cases, according to C&M, the physician is not excused from his beneficence role-related moral obligations towards the viable fetal patient, which are now in open conflict with the role-related autonomy obligations towards the woman. How could these conflicts be solved? C&M tell us that these obligations must be *balanced*, but they do not provide a criterion according to which obedience to one moral obligation can override and justifiably take precedence over another in a conflict.

We can foresee two options:

- ▶ either the autonomy of the pregnant patient is respected, overriding the beneficence-based and role-specific moral obligations of fetal surgeons towards the fetus or
- ▶ the beneficence, role-specific moral obligations of fetal surgeons towards the viable fetus override the respect for autonomy due to the pregnant patient.

In view of the fact that there is no hierarchical relationship between the principle of respect for autonomy and the principle of beneficence as proposed by Beauchamp and Childress, and on which C&M apparently rely, a morally justified choice must be made in favour of one of those principles. How can such a choice be made in a morally justified fashion, that is, in a way that does not compromise fetal surgeons' role-related moral obligations, is something C&M do not say.

In the context of MFS, if a choice is made in favour of the respect for the autonomy of pregnant patients, as we suspect it would be the case, we cannot foresee a justificatory argument that ignores the independent moral status of that type of patient as a person and eventually a bearer of human rights. After all, that status is conferred to 'normal' average adult pregnant women by all comprehensive moral theories, not to mention also the law. If that is the case, there is no conflict between obligations towards two patients that would have an egalitarian moral status without degrees. C&M are constructing a conflict that they cannot even develop consistently within their own framework. Although they claim that their approach to the 'ethics' of MFS differs significantly from those that rely on claims for or against the independent moral status of the fetus, in that it does not introduce the 'paralyzing and intractable'^v debates about sentience, personhood and human rights, we believe their approach cannot avoid making some tacit

assumptions from those debates. A patient which is also a person and a rights bearer cannot be addressed by a physician in the same way a fetal patient is, especially when, in order to comply with one's moral obligation towards the fetus, one must intervene, physically, on another patient to whom we owe respect as a patient and as a person and a rights bearer outside the context of a hospital.

When a conflict of duty arises in the context of MFS, fetal surgeons cannot thus appeal exclusively to their role-related moral obligations.^{vi} The dilemmas the approach of C&M is purported to avoid, such as the debate about the independent moral status of fetuses, are not avoided at all, since that issue will come back to the table whenever there is a conflict of duty involving the respect for the autonomy of pregnant women and the beneficence-based obligations physicians have towards viable fetuses in MFS.

CONCLUSIONS

Our aim was to uncover some of the limitations of the approach of C&M to the ethics of MFS. Although the topic deserves further thought, it was not our aim to discuss whether moral status is something we can derive from the position one assumes in the context of special social relationships, like the one that is established between a patient and his or her physician.

What we did was to check the *coherence and consistency* of the proposal of C&M *with their own foundational assumptions*, including their justification of the concept of the fetus as a patient and of the nature of fetal surgeons' obligations towards pregnant and fetal patients. We recognise that we have been very critical of the position of C&M, but offered no alternative in return. We are working on such an alternative. The later will not avoid the debate about the moral status of the fetus; a debate that will always be, inevitably, in the background of any attempt to morally justify what is owed to pregnant women and fetuses by those who are in charge of their medical care. The justification of the moral obligations pregnant women have towards their fetuses in the context of care is also inescapable and cannot be made on the same terms of the justification of physician's moral obligations, since the relationship that is established between woman and fetus cannot be defined in terms of medical care.

One can even imagine that there is no relationship at all between pregnant women and fetuses, for it can be sustained that the latter are entities that cannot engage in moral interactions. For now, it is however enough to say that the debate about the moral obligations of physicians towards the fetus cannot be transposed to the debate about the moral status of pregnant women and fetuses.

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^vThe principle advantage of for research ethics of the ethical concept of the fetus as a patient (...) is that the ethics of research on pregnant women is conceptually independent of the discourses of personhood, fetal rights, and the unborn child. The unnecessary and unwarranted introduction of such discourses will only polarize and therefore paralyze research ethics and therefore paralyze clinical research on pregnant women because the application of these discourses will result in philosophically irresolvable competition among sharply differing candidates for an acceptable risk-benefit ratio. The abortion debate will simply replicate itself in the ethics of research on pregnant women with the same paralyzing consequences that it has had for the ethics of abortion.⁷

^{vi}Note that we have repeatedly referred to fetal surgeons' moral obligations. We do not mean that only fetal surgeons have moral obligations towards fetal and pregnant patients in MFS. When we say 'fetal surgeons', we mean also all those who are involved in the care of pregnant patients for fetal benefit.

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