Philosophy and Theology

The ethics of fetal surgery raises numerous questions. In this reflection, I would like to consider only three of them. Is the fetal human being a "patient" and, if so, under what conditions? Why does the "reduction" of a twin pregnancy to one baby cause such difficulty for defenders of abortion? Is it morally permissible to prevent a dying fetal twin from bringing about the death or serious injury of a healthy fetal twin by means of umbilical cord occlusion?

Arguably the most prominent scholars exploring the ethical questions about fetal surgery are Frank A. Chervenak and Laurence B. McCullough. In a series of books and articles, they have established themselves as the foremost authorities in the area. How do they answer the first and fundamental question about fetal dignity? Chervenak and McCullough point out that there has been a long-standing debate about whether or not the human fetus has independent moral status ("Ethics of Fetal Surgery," *Clinics in Perinatology*, June 2009). As in many other debates, there has never been a definitive answer to the question that settles the matter once and for all to the satisfaction of all parties. Those in a given theological tradition disagree with those in others and often disagree among themselves as well. In a similar way, philosophy offers many different methodologies which lead to different conclusions about the issue, so reasonable people still disagree about whether the fetal human being should be accorded basic human rights.[1] So Chervenak and McCullough hold that the only rational course of action is to abandon the debate about whether or not the human fetus is a patient with independent moral status, and to pursue a question that they think is answerable, namely, whether the fetal human being has dependent moral status. In "Ethics of Fetal Surgery" they write, "A philosophically more sound and clinically more useful line of ethical reasoning is that the moral status of the fetus depends on whether it is reliably expected later to achieve the relatively

[1]Laurence B. McCullough and Frank A. Chervenak, *Ethics in Obstetrics and Gynecology* (New York: Oxford University Press, 1994): 97–101.

unambiguous moral status of becoming a child and, still later, the more unambiguous moral status of becoming a person. This is called the dependent moral status of the fetus." On McCullough and Chervenak's view, the human being in utero has dignity when viable and when the pregnant woman presents herself to the doctor in order to secure help for the human fetus.

This proposal to shelve the debate about the independent worth and focus on dependent status fails for a number of reasons. First, the view of McCullough and Chervenak is self-defeating. They themselves presuppose a particular methodology, a methodology that is not universally accepted. So if we ought to abandon projects that do not make use of a universally accepted methodology, they too should abandon their project.

Second, the McCullough–Chervenak position rests on feigned neutrality. It is possible to be agnostic in theory about the value of human life in utero, but it is not possible to be agnostic in practice when one is treating fetal human beings. A physician treating a pregnant woman must either act as if the human being in utero is a second patient with independent worth or not. It is grossly irresponsible to "shelve" the question of the moral status of the fetal human being because a physician treating a pregnant patient who has asked for medical action affecting the unborn must act in one way or the other. If the physician harms the fetal human being, he or she gives a practical answer (whatever the theoretical stance) that the human fetus has no independent value.

McCullough and Chervenak assert that the fetal human being has dependent status when and only when he or she is viable *and* the pregnant woman presents herself to the physician and asks for treatment for her unborn child. McCullough and Chervenak present no argument for the importance of viability for moral worth. The thesis is simply asserted, the definition of viability is explained a bit, and the conclusion is reasserted.

However, viability is irrelevant to moral status. In cases of conjoined twins, one twin may be physiologically dependent on another, and yet no one questions whether conjoined twins have equal basic dignity to other persons. Furthermore, viability varies according to access to technology, but it is absurd to say that the moral worth (even the dependent moral worth) of a person varies according to the person's location—that is, whether the person is near a hospital or far away.[2] The ability to live in one location rather than another is irrelevant to moral status.

McCullough and Chervenak do give an argument for why the decision of the woman is relevant to whether or not the fetus is a patient, namely, that independent moral status arises later and will not be possible without the decision of the woman to continue the pregnancy: "This is because the only link between a previable fetus and its later achieving moral status as a child, and then a person, is the pregnant woman's autonomy, exercised in the decision not to terminate her pregnancy, because technologic factors do not exist that can sustain the previable fetus ex utero. When the

[2]For more on this topic, see section 4.1.2 of my book *The Ethics of Abortion: Women's Rights, Human Life, and the Question of Justice* (New York: Routledge, 2011).

pregnant woman decides not to terminate her pregnancy and when the previable fetus and pregnant woman are presented to the physician, the previable fetus is a patient."

This argument is unsound. It is false that the only link between a previable fetus and its later achievement of moral status is the choice of the woman. If by "link" they mean a necessary (but not sufficient) condition, they are correct that a necessary condition for a child's reaching the age of two is that the mother does not abort him or her, but they are incorrect in claiming that this is the *only* condition. Other links, understood in this sense, include that the child does not die of natural causes prior to two years of age, that the child is not killed shortly after birth, and that a forced abortion is not performed, among many others. If we understand the "link" of a woman's choice not to have an abortion as a sufficient condition, similar problems arise. Since Chervenak and McCollough's argument rests on a false premise, it does not justify their conclusion.

Chervenak and McCollough's treatment of fetal surgery is flawed in other ways as well. They write,

> To protect the woman from being coerced, her husband or partner and other family members should be reminded that although they may have strong views for or against her participation, their role should be to support and respect the woman's decision-making process and its outcome. Their relationship to her is primarily one of obligation to respect and support her decision. Family members do not have the right to make decisions for her. When necessary, this aspect of the informed consent process should be made clear to family members. Clinical investigators should ensure that everyone involved in the consent process takes a strictly nondirective approach. Although not currently required in federal consent regulations, prospective monitoring of the consent process (eg, in random sampling) could be used to enforce the nondirective approach.

Chervenak and McCollough offer no justification for any of these controversial claims. It is true in current U.S. law that the woman has the legal right to make the decision to abort. Whether or not she also has the moral right to fetal homicide (as performed in a pregnancy "reduction") remains a topic of vigorous disagreement. Legally, there is no obligation whatsoever for family members or anyone else for that matter to refrain from voicing their opinions about her contemplated choice as much as they like. At least in the United States, the first amendment of the Constitution protects free-speech rights, which are not rescinded in family relationships or when one takes the Hippocratic Oath. In ethical terms, there is simply no obligation "to support and respect" someone else's decision, whatever that decision may be. If a decision is an ethically permissible or commendable one, then it should be respected and supported. If a decision is an ethically impermissible one, it should be neither respected nor supported. The *person* who makes the decision should be respected and supported, as is appropriate for all persons with dignity, but not the *decision* itself. Clear-headed people have no obligation to support and respect ethically wrong decisions, such as the decision to drive under the influence. Love and respect for others, including the potential drunk driver, demands that we seek ways to help them avoid wrongful choices, including in many circumstances trying to talk them out of it.

On a positive note, Chervenak and McCollough are correct in noting how fetal homicide impedes scientific research: "From the perspective of investigators, to obtain

the cleanest results about outcomes for fetuses and future children, one would not want any pregnancies in which fetal surgery occurred to result in elective abortions." In his article "Fetal Therapy: Practical Ethical Considerations," Yves Ville makes the same observation: "Owing to the high incidence of TOP [termination of pregnancy] following prenatal diagnosis of these conditions, comparative studies are going to be difficult to perform" (*Prenatal Diagnosis*, July 2011).

In this discussion, TOP is a favored term, but this is unfortunate, because "termination of pregnancy" (TOP) is ambiguous and euphemistic. It is ambiguous because vaginal birth, cesarean section, and spontaneous miscarriage also "terminate" a pregnancy and because abortion can take place in cases where no "termination of pregnancy" occurs, as in the fetal homicide of one twin when the other twin is left alive. The acronym TOP is euphemistic because, even more than the phrase "termination of pregnancy," it sounds benign, innocent, and noncontroversial. The reality is better conveyed by the more accurate, honest, and precise term "abortion."

Ville raises other ethical questions about fetal surgery. He notes a certain bias among practitioners for giving treatments, which may not be in the patient's best interest: "Offering treatment for a fetus demonstrating objective signs for an irreversibly poor outcome is questionable in that the benefit of treatment can be expected to be little if any and medical enthusiasm may also be strengthened with the view to improve one's own practice with the procedure." A surgeon's desire to strengthen surgical skills or pioneer new techniques may come into conflict with providing what is best for both patients.

Ville also claims that "prenatal diagnosis is the only field of medicine in which termination has a role in the management of a disease." This is false, because "termination" of a patient is not management of a disease. As Jorge Garcia points out in his judicious discussion of physician-assisted suicide, killing is not the relieving of pain. Garcia's reflections can be extended to also show that killing is not managing a disease:

> Ending [a patient's] pain cannot be a benefit to her for the usual reason, then, because [in physician-assisted suicide] the patient does not experience relief and thereafter live pain-free. As the end of her pain here does not improve her experience, neither does it improve her life, her condition. Rather, she (her integrated human life) ends along with the pain, and *she* is in no condition at all during the period when she is lifeless. We cannot, then, meaningfully compare it with her condition over the same time had she lived. . . . Thus, it is difficult to see just what benefit our killing renders her, as it *improves* neither her experience, nor her life, nor her condition.[3]

Just as killing people to relieve their pain is not pain relief, so too abortion is not management or cure of disease. Indeed, if we define disease as a lack of proper biological functioning to a greater or lesser degree, fetal killing induces the maximum of disease, complete nonfunctioning.

About fetal moral status Ville writes, "Although the concept of the fetal status gaining more independence from its mother with gestational age is universally accepted, its importance is to be balanced with other issues, including maternal safety

[3] J. L. A. Garcia, "The Doubling Undone? Double Effect in Recent Medical Ethics," *Philosophical Papers* 36.2 (2007): 245–270, original emphasis.

as well as the severity of the fetal condition." However, it is not universally accepted that fetal status is linked to gestational age such that the more physiologically developed the fetus becomes, the greater the value the fetal human being has. This gradualist or developmental view of the value of human life prior to birth is controversial and is rejected by many people on a variety of grounds. Obviously, those who oppose fetal homicide because all human life has equal basic value reject the view that fetal worth develops in the course of pregnancy.[4] But many of the most prominent supporters of abortion, such as Peter Singer, Michael Tooley, David Boonin, and Judith Jarvis Thomson, also reject this view. Ville offers no argument for this view, but simply assumes without justification that the developmental view is obviously true.

Indeed, Ville's view of fetal status is inconsistent. He writes,

> The issue of fetal analgesia touches on the surgical approach itself inasmuch as on the "primum non nocere" principle in all procedures invasive to the fetus itself. It is well established that very preterm neonates experience pain, and related autonomic neural connections function from around 22 weeks of gestation. It is therefore important that any directly invasive fetal procedure be preceded by appropriate fetal analgesia. … Practitioners who undertake termination of pregnancy at 24 weeks or later should also consider the requirements for fetal analgesia or sedation prior to feticide before inducing labor.

This approach surely does not work. If a fetal human being should not be harmed (*primum non nocere*), it is true that this principle requires the use of analgesia for operations in which the human being in utero may suffer, but a fortiori it is also true that the more significant harm of death should not be inflicted. The *primum non nocere* principle either applies to the unborn or it does not.

This disjunction is also apparent in twin pregnancies. The "reduction" of a pregnancy from twins to a single baby is controversial even among those who otherwise staunchly defend fetal homicide. Responding to a *New York Times Magazine* story by Ruth Padawer that raised the issue in public awareness, William Saletan's article in *Slate*, "Flaws in Pro-Choice Logic," puts the spotlight squarely on the problem for defenders of abortion.[5] Why should defenders be troubled by abortion that reduces twins to a single baby? They clearly are, but they have a difficult time articulating why. Saletan recognizes the schizophrenic thinking of many defenders of fetal homicide:

> Embryos fertilized for procreation are embryos; embryos cloned for research are "activated eggs." A fetus you want is a baby; a fetus you don't want is a pregnancy. Under federal law, anyone who injures or kills a "child in utero" during a violent crime gets the same punishment as if he had injured or killed "the unborn child's mother," but no such penalty applies to "an abortion for which the consent of the pregnant woman … has been obtained." Reduction destroys this distinction. It combines, in a single pregnancy, a wanted and an

[4] For a philosophical justification for the equal basic worth of all human beings, see my *Ethics of Abortion*; on the developmental view and why it is mistaken, see section 4.3. See too my article "Equal Rights, Unequal Wrongs," *First Things* 204 (August–September 2011): 21–23.

[5] Ruth Padawer, "The Two-Minus-One Pregnancy," *New York Times Magazine*, August 10, 2011, http://www.nytimes.com/2011/08/14/magazine/the-two-minus-one-pregnancy.html. William Saletan, "Flaws in Pro-Choice Logic," *National Post*, August 17, 2011, http://fullcomment.nationalpost.com/2011/08/17/william-saletan-the-flaws-in-pro-choice-logic/.

> unwanted fetus. In the case of identical twins, even their genomes are indistinguishable. You can't pretend that one is precious and the other is just tissue.

Killing one twin in utero while letting the other live brings into full consciousness the doublethink that is usually merely implicit, revealing no minor cognitive dissonance.

One final question about fetal surgery is the ethics of umbilical *cord occlusion* in cases of twin–twin transference syndrome.[6] In such cases, the twins are connected by a shared placenta. One of the twins is dying (from imminent, irreversible cardiac failure, for example), but the other twin is healthy. When the first twin dies, the other twin has a high risk of death or permanent, serious neurological injury.

Is it morally permissible to perform umbilical cord occlusion to prevent the dying twin from bringing about the death or serious injury of the healthy twin? Umbilical cord occlusion cuts off the circulatory link between the twins, preventing the dying twin from harming the healthy twin, but at the same time it cuts off the life-supporting link of the dying twin to the placenta. The one action brings about two effects, one good and the other bad. In terms of double-effect reasoning, the question in part is the following: Is umbilical cord occlusion selective feticide or is it the foreseen but not intended death of one twin to save the other twin?

Supposing for the sake of argument that the death of the weaker twin is not desired as a means or an end in itself, and that the fourth condition of double-effect reasoning is met, namely, that there is a just cause for allowing the evil effect. My view is that the justification or condemnation of umbilical cord occlusion depends on how one understands the distinction between intended effects and merely foreseen effects. If all the certain or simultaneous effects of the action are intended, then according to double-effect reasoning, it is impermissible to bring about the negative effect—specifically, fetal demise following umbilical cord occlusion. Although others would disagree with me, it is my opinion, however, that if the intended effects are understood to be limited to what is chosen as a means or an end, as part of the plan, or as desired effects,[7] then umbilical cord occlusion would be permissible according to double-effect reasoning, despite its certain and simultaneous negative effect of accelerating the death of the dying twin. It is permissible to not prevent the foreseen death of one person in order to save the life of another.

Fetal surgery doubtless gives rise to other ethical issues as well, but twin–twin transfusion syndrome is among the most difficult. Without a cogent answer to the questions of fetal dignity and reduction of pregnancy, the likelihood of coming to a just solution in cases of twin–twin transfusion syndrome is remote.

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[6]For the medical background, see, for example, Ramen H. Chmait and Ruben A. Quintero, "Operative Fetoscopy in Complicated Monochorionic Twins: Current Status and Future Direction," *Current Opinion in Obstetrics and Gynecology* 20.2 (April 2008): 169–174; and A. Cristina Rossi and Vincenzo D'Addario, "Umbilical Cord Occlusion for Selective Feticide in Complicated Monochorionic Twins: A Systematic Review of Literature," *American Journal of Obstetrics and Gynecology* 200.2 (February 2009): 123–129.

[7]See, for example, John Finnis, Germain Grisez, and Joseph Boyle, "'Direct' and 'Indirect': A Reply to Critics of Our Action Theory," *The Thomist* 65.1 (January 2001): 1–44.