Legal Rights and the Maternal-Fetal Conflict

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In 1973, the landmark and controversial court case Roe v. Wade came to a close when the U.S. Supreme Court ruled that a woman's Constitutional right to privacy negated abortion legislation [1]. This court ruling enabled women to terminate pregnancies up to the point of fetal viability [2] (the point in fetal development at which a delivered baby can survive without interfering with the body of the mother[3]). In humans, fetal viability is considered to occur at 24 weeks of gestation[4].

In a related case, *Doe v. Bolton*, the US Supreme Court supported abortion rights after the point of fetal viability in order to preserve women's lives and continuing health[5]. The concept of health, as defined by the Supreme Court in *Doe v. Bolton*, includes "all medical, psychological, social, familial and economic factors that may potentially encourage a decision to obtain an abortion"[5]. Thus, the mother's life and health takes precedence over the life of the fetus right up until birth. The ruling from this case is controversial due to the partial birth abortion (or late term abortion) debate. In this procedure, a woman's cervix is dilated over several days, the fetus is extracted feet first, the skull is perforated, and the brain is partly evacuated[6]. The fetus is then delivered deceased, but otherwise intact.

Fifteen years later, in 1988, the Canadian Supreme Court abolished its abortion law in *R. v. Morgentaler*. The Supreme Court determined that restrictive abortion provisions violated women's rights as set out in the 1982 Canadian Charter of Rights and Freedoms[2]. The court ruled that the Criminal Code violated women's rights because "forcing a woman, by threat of criminal sanction, to carry a fetus to term unless she meets certain criteria unrelated to her own priorities and aspirations, is a profound interference with a woman's body and thus a violation of security of the person"[7].

Although abortion has been legal for thirty years in the United States and fifteen years in Canada, much controversy and debate surrounds this issue as well as that of maternal-fetal conflict. Maternal-fetal conflict occurs when a pregnant woman's interests, as she defines them, conflict with the interests of her fetus, as defined by the woman's physician[3]. A conflict of this nature may occur when a pregnant woman decides not to comply with recommendations that her physician considers to be in the best interest of the fetus. What is the best method of resolving this situation? What are the moral obligations of the physician to the pregnant woman and to the fetus?

In order to answer the above questions, it is necessary to examine the issues of when human life begins and the moral status of the fetus. These concerns drive the ongoing debate between abortion advocates and pro-life supporters.

The Beginning of Human Life

When does human life begin? Some ethicists believe human life begins when the female egg is fertilized by the male sperm, forming one cell [3]. This one cell contains the complete genetic blueprint for every detail of human development – from sex, to hair and eye colour. From this moment, some believe that the embryo has the status of a person [3,4].

Others believe that life begins from the 14th day after conception, when nidation of the embryo has occurred and the primitive streak is present[4]. Following menstruation, development of the epithelial membrane which lines the inner surface of the uterus allows for embryo attachment to the maternal uterine wall. The primitive streak is an elongated band of cells that forms the axis of an embryo[8]. It is the site of cell activity where the middle layer of the embryo develops and it also determines the basic body plan[9].

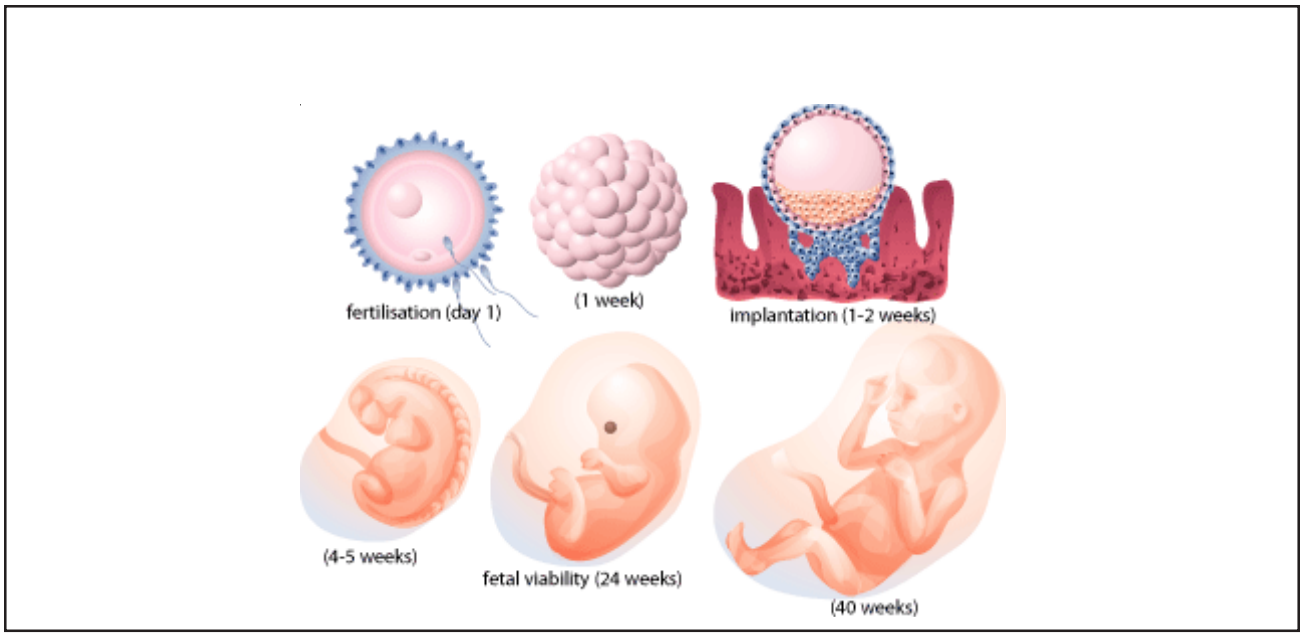

Figure 1. An overview of human fetal development.

There are others that believe life begins at the moment of birth and that the fetus does not have an independent moral status while in utero [3,4]. Another opinion is that life begins 28 days after birth [4].

Moral Status of the Fetus

There are currently three ways of approaching this issue. The fetus can have the same rights as a child, have no rights, or have increasing rights with advancing gestation[9].

Full Fetal Rights

If the fetus is considered to have the full rights of a person, then it should be treated as a separate entity from the mother [9]. Thus, the pregnant woman and the fetus should be treated as two individual patients. In fact, the medical model for the biological maternal-fetal relationship has shifted emphasis from unity to duality, and the fetal organism is considered a distinct patient[3].

A major problem with this concept is fetal dependence on the mother. This total dependence has the potential to cause serious conflict between maternal and fetal rights[9]. Fetal diagnosis and therapy have undergone developments which have optimized fetal outcome[3], however any fetal diagnosis or therapy performed to improve fetal outcome must include the involvement of the pregnant woman. In most cases, the pregnant woman would agree to undergo the proposed intervention. However, there are cases where the pregnant woman does not. In these circumstances, granting full rights to the fetus infringes upon the mother's autonomy. Autonomy is one of the fundamental principles of biomedical ethics[9].

Biomedical ethics is defined as "the application of general ethical theories, principles and rules to problems of therapeutic practice, health care delivery, and medical and biological research" [10]. In order to address ethical issues and resolve conflicts, biomedical ethics emphasizes the use of moral principles. These are; respect for autonomy, beneficence, and justice[10]. The principles of autonomy and beneficence are viewed as the primary factors involved in the maternal-fetal conflict[11].

The right to be free from unwanted bodily invasions and to control one's own life is fundamental to the pregnant woman's right to security of the person[7]. Maternal right to privacy is also supported by other concepts and rights, specifically that of autonomy. The concept of a person's autonomy is their right to choose how to live their own life[9]. The pregnant woman should be allowed the freedom to decide upon alternative courses of therapeutic action based on her values and beliefs[4].

The principle of beneficence requires an individual to act in such a way as to reliably produce more good than harm in the lives of others[3]. With respect to maternal-fetal relationships, the physician should assess objectively the various therapeutic options that may exist. The physician should implement those that will most likely offer the patient greater benefit over risk[4]. At the same time, the physician should consider the well-being of the fetus and also try to offer the fetus the greater benefit over risk[4]. Therefore, the physician has a beneficence-based obligation to the fetus as well as to the mother, which can put the physician in a difficult position when maternal-fetal conflicts arise.

For a one-patient model, where the pregnant woman and fetus are recognized as one entity, the physician must recommend a therapy where the combined maternal-fetal benefits outweigh the combined maternal-fetal burdens. For a two-patient model, a more difficult decision is required of the physician. A single treatment recommendation for both patients may not be reasonable in terms of the beneficence principle alone. This is because the principle of beneficence does not take into account balancing the burdens of one patient against the benefits of another[3].

Some argue that moral obligations are greater to those who are most in need. Therefore, in cases of maternal-fetal conflict, the principle of beneficence applies more strongly to the fetus, since the fetus has less to gain and more to lose by reversing the priority. It has also been argued that while a woman has the right to terminate her pregnancy, once she decides not to exercise this right, she is obligated to behave in a manner that contributes to fetal development[3].

Assigning full rights to the fetus has the potential of encouraging legislation against maternal activities that may harm the fetus, such as excessive alcohol consumption or drug abuse. This ultimately infringes upon the mother's autonomy. Some have proposed that privacy is not an absolute right and that the woman's right to privacy concerning her pregnancy may be legally overridden after fetal viability[3]. In situations of conflict, some court rulings have supported the interests of the fetus over those of the mother, both in early and late term pregnancy.

A classic case of maternal-fetal conflict involves a pregnant woman presenting with a well-documented complete placenta previa and refusing to undergo cesarean section, insisting instead on a vaginal delivery[3]. Placenta previa is a condition in which the placenta is in the lower segment of the uterus, partially or completely obstructing the birth canal[12]. Unanimous medical opinion would state that attempting to deliver through the vaginal route would most likely result in death to both the mother and fetus[3]. In this particular case, it is considered ethically acceptable for the caregivers to refuse the mother's wishes of a vaginal birth. This decision is supported by the value of medical beneficence, which is "the prevention of unnecessary death and the prevention, cure or management of morbidity"[3]. Caregivers in this situation may seek added persuasiveness or turn to the legal system to obtain a court order to force the mother to have a cesarean section.

A more recent appellate decision on maternal-fetal conflict is that of the Angela Carder case [13,14]. In 1987, the 27-year-old woman was hospitalized at the 25th week of gestation with metastatic terminal sarcoma, a disease she had battled during her adolescence. Angela Carder agreed to a medical plan which consisted of palliative therapy, attempting to extend her life to the 28th week of gestation. It was thought that if the baby was delivered at 28 weeks of gestation, there would be reasonable expectation for survival. Unfortunately, Angela's condition deteriorated and she required intubation and sedation. She was judged to be terminally ill and near death.

The hospital administration became concerned about the well-being of the fetus and despite the opposition of her attending physicians and family, obtained a court order authorizing a forced cesarean section. The judge ruled in favour of the cesarean section. Angela unexpectedly regained consciousness and was informed about the judge's order. Although she expressed her disapproval with the decision, a cesarean section was performed. Several hours following the operation, the baby died. Two days later, so did the mother.

This case was reviewed by the Appeals Court, District of Columbia, which was critical of the trial judge's decision. This judge had based his decision

on balancing the rights of the mother against the interests of the state in the life and well-being of the fetus. He reached his decision by assessing that the State's interest in protecting the fetus outweighed whatever rights or interests the dying woman had. This case is one specific example of the many court-ordered forced cesarean sections that have occurred in the United States[12]. It clearly demonstrates the violation of a woman's autonomy.

No fetal Rights

Some argue that the fetus has no moral status independent of the mother, but acquires moral status at birth. It is the emergence into the social world that is thought to transfer moral status[9]. This implies that a pregnant woman has the moral right to abort a viable fetus, but not to kill her newborn infant[3].

Assigning no rights to the fetus strengthens the right of maternal autonomy. In this scenario, court-ordered treatments or interventions are never justified[3]. Data obtained on court-ordered obstetric interventions has suggested that in approximately one-third of the cases where court authority was sought for a medical intervention, the medical treatment was considered wrong or harmful in retrospect [11].

Under the principle of maternal autonomy, once a pregnant woman has made an informed decision to refuse a treatment recommended by the medical team, there must be complete acceptance of her decision with no efforts made to persuade her. The right to bodily integrity and autonomy supports the concept of informed consent, which allows competent patients to accept or refuse medical treatment for their own reasons[3]. The principle of informed consent requires a physician to respect the wishes of a mentally competent adult in situations of medical decision making[3].

Despite these principles, the Committee on Bioethics for the American Academy of Pediatrics state that "three conditions must be fulfilled for a physician to consider opposing the woman's refusal of a recommended intervention: (i) there is reasonable certainty that the fetus will suffer irrevocable and substantial harm without the intervention, (ii) the intervention has been shown to be effective, and (iii) the risk to the health and well-being of the pregnant woman is negligible"[15].

Fetal Rights Acquired with Advancing Gestation

Others argue that the fetus acquires increasing moral status as it advances in gestation. Are there ethical differences between aborting during early pregnancy versus during late pregnancy? Society perceives moral differences between an early abortion and termination of a viable full term fetus. This suggests that the moral status of the fetus does increase with gestation[9].

Legal issues exist with regards to maternal-fetal conflict. The law "does not oblige physicians to resort to court orders demanding pregnant women to undergo treatment or alter their behaviour for their fetus"[3]. There are "no statutes, regulations, or court decisions in any jurisdiction that require physicians to seek legal review of a competent pregnant woman's decision to decline medically indicated treatment or to avoid behaviour that poses a risk of harming her fetus" [3]. There is no legal penalty to the physician who fails to seek a court order forcing obstetric treatment. Therefore, the physician must accept the ethical responsibility for his or her decision in seeking judicial authority to treat a pregnant woman against her will, but by taking the matter into a public judicial forum, the patient-physician confidentiality clause is breached[3].

Summary

It is clear from the relevant case-law that this issue is still very much under debate (at least in the U.S.). If the fetus is assigned full rights, then society is required to protect those rights as it would for a live baby. This is the case even if the fetus's rights conflict with maternal autonomy. If the fetus has no rights, then a viable fetus is not protected if the mother jeopardizes its existence. If the moral status of the fetus increases with advancing gestation, then a viable fetus has greater moral status than a newly fertilized egg and it is reasonable to intervene if the mother's behaviour jeopardizes the fetus near term[9].

There exists a theory that the fetus is not a separate biological entity at all. Rather, it is dependent on the

mother's body until near term. The mother and fetus are involved in a symbiotic relationship in which the mother is the moral guardian. If significant differences arise in the interests of the mother and fetus, the mother has the responsibility to consider the interests of both in making an informed decision regarding medical treatment. If a conflict arises, the competent mother's rights to personal autonomy should prevail over the lesser rights of the fetus early in gestation. As the fetus matures and acquires greater moral status, the situation may become less clear[9].

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