

## Fetal survival—who decides?

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*In this paper Iain McFadyen highlights a modern ethical dilemma. In each case the fetus was recognised to be in danger, but in both cases the advice given in the fetal interest was refused by the mothers. Both the mother and the physician were concerned for the fetus, but their differing actions and reasons pose the dilemma – who decides?*

### Mother, fetus and physician

Medical prediction and prognosis are not scientific certainties. Until recently this was particularly true in obstetrics but with greater understanding of fetal physiology and development of informative investigations, the probability of an accurate assessment being made has very much increased. Fetal medicine is now closely approaching other previously more advanced specialities. The ethical situation, however, has not much changed since the 17th century when the chance of death in childbirth was around 1:40, and stillbirth or death in infancy were everyday happenings for most families. Then it was generally accepted that the parents had the final say regarding fetal survival. Now the maternal risk in pregnancy is minimal and the stillbirth rate is about 1 per cent, the situation has changed considerably. Perinatal care today is concerned with delivering a child which can achieve its full developmental potential, rather than with the mere question of survival. Now, therefore, is an appropriate time to review the ethical position of mother, fetus and physician in relation to the fetus.

#### CASE A

A fit young primigravida of 23 had a pregnancy which was uneventful until it was prolonged beyond an accurately estimated date of delivery. The mother then lost weight and was advised that labour should be induced lest harm come to the fetus. This advice both she and her husband refused to accept, nor would they allow other investigations be carried out. Labour started spontaneously 17 days after the estimated date of delivery. Signs of severe fetal oxygen deficiency appeared with the onset of uterine contractions. After considerable persuasion the parents agreed that a Caesarean section should be carried out. The baby was delivered in a very asphyxiated condition with biochemical changes confirming the intra-uterine malnutrition which had been predicted.

He did not respond to resuscitation satisfactorily and died 3 days later.

#### CASE B

In the same week another patient was admitted in premature labour. Effective treatment was started but after only a few hours of this the patient discharged herself from hospital. That day she was admitted to another hospital, again in premature labour. Once more treatment was started and again the patient disregarded medical advice and left. She could not thereafter be traced.

### The ethical dilemma

These two cases focus attention on a modern ethical dilemma. In each the fetus was recognised to be in real danger of dying or of retarded development. In neither was the advice given in the fetal interest accepted by the mother. Twenty years ago predictions of this nature could not be made with similar accuracy nor was treatment then available which significantly improved the outlook for the fetus. This is no longer true. Accepting that some cases who have no problems are bound to be included in any group considered to be at high risk for fetal or neonatal morbidity, who has the right to make decisions about fetuses which have serious problems *in utero*?

There are many reasons for a mother refusing treatment. She may be psychiatrically unstable or mentally subnormal, but this is true in few cases. She may not understand the reasons for the advice offered, either because of a poor command of English or because anxiety clouds her perception. There may be worries about other members of the family to whom she gives priority. Fears about the normality of her child or on the nature of the treatment may be rationalised into reasons for rejecting advice. Cultural difficulties may also determine her attitude. There are, however, other pressures. Recent newspaper articles and television programmes have implied that advice given may be based not on the patient's best interests but on the convenience of the doctor. Because of this some patients cannot be persuaded that advice offered is in the best interests of their fetuses. They genuinely feel that they are doing their best for their babies while the medical attendants are convinced that they are not. Thus the horns of this dilemma are

sometimes occupied by the mother on the one, confronting the physician on the other: both concerned about the health of the fetus.

### Other aspects

The dilemma also has other aspects. The fetus suspected of having an abnormality poses a problem, as do twins. There are occasions when a fetus is suspected of having a congenital anomaly but proof is not available. Meningo-myelocele may be suspected from an X-ray in late pregnancy but the final proof is observation of the lesion after delivery. Should such a child show signs of oxygen lack in labour, how active should the obstetrician be in his management? If the baby is normal then it should be delivered as expeditiously as possible, by Caesarean section if necessary. If the baby is abnormal (or if there is the likelihood of abnormality) is it reasonable to subject the mother to major surgery? On the other hand if there is an anomaly which prejudices future development should not that fetus also have optimal care so that it may eventually achieve as much of its developmental potential as possible.

Abnormality in one of twins, where the other is normal so far as can be discovered, poses a real problem where termination of the pregnancy is being considered. Another situation which can arise with twins is that later in the pregnancy the growth of one may become increasingly retarded. Had it been alone in the womb a decision about the most appropriate time for delivery (which may

have to be premature) can be made with a reasonable degree of certainty. The normally growing twin however may come to harm through being delivered prematurely. Who has the priority? Such problems are even more common with triplets. Who rules then: the majority?

### Conclusion

It seems reasonable that the final decision on fetal wellbeing and survival should be the parents'. The present reality is that treatment of the mother against her wishes would constitute an assault. The only similar situation in medical practice is that of the child who needs a blood transfusion but permission is refused by the parents. He is then made a Ward of Court. In psychiatry and infectious diseases, patients are committed to hospital both for their own safety and the safety of the community. In obstetrics however the only people whose safety is under consideration are the mother and her fetus. Education and persuasion would appear to be the answer. Logical and rational thought, however, are frequently not the cornerstones of decision making. Recent public discussion on the wearing of crash helmets and seat belts underlines this. Legal compulsion could be introduced to make the fetus a Ward of Court, but this would undermine the doctor-patient relationship. There would also be situations in which the marriage might founder if the wife agreed to treatment but the husband refused, or *vice versa*. What was until recently a purely philosophical point has now become a reality of practical medicine.