Ethical Dimensions of Multiple Pregnancy

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Disclosure Statement

• I do/do not have relevant financial relationships with commercial interests related to the content of this presentation.
Learning Objectives

• 1. Identify the different senses of the fetus as a patient

• 2. Apply basic ethical principles to the management of clinical-ethical challenges in the management of multiple gestations

• 3. Use the professional responsibility model of obstetric ethics for the management of multiple pregnancies and counseling patients and families to include multifetal pregnancy reduction.
Ethical Challenges Presented in the Management of Multiple Pregnancies

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Ethics: Multiple Pregnancies

- Obstetric Ethics
- The Fetus as a Patient
- Multiple Pregnancies
  - Selective Termination
  - Twin to twin Transfusion
  - Discordant Obligations
Morality

Mores

Right & Wrong Behavior

Good & Bad Character
Bioethics: Disciplined Study of Morality

- Physicians
- Patients
- Institutions of Health Care
- Health Care Policy
CLINICAL
DATA

PRACTICE
ARGUMENT
Criteria for Rigorous Ethical Analysis & Argument for Normative Ethics

- Clarity
- Consistency
- Coherence
- Clinical Applicability
- Clinical Adequacy
- Completeness

McCullough LB, Chervenak FA, Oxford Univ Press, NY, 1994
Normative Ethics

Ethical Analysis

• Identifies component elements of issues in terms of ethical principles and virtues

Ethical Argument

• Utilizes ethical principles and virtues as premises from which conclusions can be drawn

McCullough LB, Chervenak FA, Oxford Univ Press, NY, 1994
Inadequate as the Basis of Obstetrics Ethics

- The Law
- Religious Beliefs
- Professional Consensus
- Appeals to Authority
Primum Non Nocere

• First, Do No Harm
• Non-Maleficence
Primum Non Nocere

“As to diseases, make a habit of two things, to help, or at least do no harm.”

Epidemics
Beneficence

Bene
Good

Facere
To Do
Beneficence

Requires the physician to assess objectively the various diagnostic and therapeutic options, and to implement those that protect and promote the interest of the patient by securing for the patient the greatest balance of clinical benefits over harms.
“The art of medicine lies in balancing probabilities.”

Sir William Osler
Evidence

Beneficence

Clinical Judgment
Autonomy

Autos
Self

Nomos
Law
Respect for Autonomy

Accepts that the patient has a perspective on her interests that is based on her values and beliefs, and that the patient should have the freedom to choose alternatives based on these values and beliefs.
Informed Consent Process

• Disclosure by the physician to the patient of adequate information about the patient’s condition and management
• Understanding by the patient of the information
• A voluntary decision by the patient to authorize or refuse clinical management
Justice

Fairness

Substantive ↔ Outcome

Procedural ↔ Process
Prima Facie
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When is the Fetus a Patient?
George Engel, MD
(1913-1999)
Biological Reductionism

“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 … reductionism, the philosophic view that complex phenomena are ultimately derived from a single primary principle ...”

Engel G 1960; Chervenak FA, McCullough LB, Brent RL 2011
Biological Reductionism

• Even a very sophisticated scientific fund of knowledge will be scientifically and therefore clinically fallacious if it focuses only on the biological aspects of health and disease

• Incorporating the psychological and social dimensions is required to have a clinically adequate model to guide obstetric care and avoid clinical tunnel vision

• Biological reductionism is scientifically and clinically inadequate

Engel G 1960; Chervenak FA, McCullough LB, Brent RL 2011
Biological Reductionism

• There is an analogous fallacious reductionism in obstetric ethics

• The fallacy of ethical reductionism occurs when a model for ethics appeals exclusively to one ethical concept in complex clinical circumstances that by their very nature require consideration of complementary concepts

      Engel G 1960; Chervenak FA, McCullough LB, Brent RL 2011
Rights-Based Reductionism

• Rights-based reductionism in obstetric ethics bases it exclusively on the rights of either the pregnant woman or the fetus

• Rights-based reductionism ignores other clinically relevant ethical concepts

Engel G 1960; Chervenak FA, McCullough LB, Brent RL 2011
Fetal Rights Reductionism

- Fetal rights systematically override woman’s rights at all gestational ages
- Fetal rights systematically override woman’s rights at all gestational ages

Chervenak FA, McCullough LB, Brent RL 2011
Pregnant Woman’s Rights Reductionism

- Woman’s rights override fetal rights at all gestational ages

- Fetal rights systematically secondary to woman’s rights

Chervenak FA, McCullough LB, Brent RL 2011
Result in Ethical Disaster
Independent Fetal Moral Status

- Full or Graded

- Fetal Rights vs. Maternal Rights

- Ethical & Clinical Gridlock

Dependent Fetal Moral Status

- No

- Obligations to Fetal Patient & Pregnant Woman

- Clinically Relevant Balancing Of Ethical Obligations
Professional Responsibility Model

- Professional responsibility to patients is based on professional obligations, not rights.
- The professional obligations of obstetricians are owed to both the pregnant and fetal patient.
  - Not separate patients.
- Autonomy-based and beneficence-based obligations to the pregnant patient and beneficence-based obligations to the fetal patient must all be considered.

Engel G 1960; Chervenak FA, McCullough LB, Brent RL 2011
Professional Responsibility Model

• Rights-based reductionism has an appealing simplicity
• Rights-based reductionism is ethically incomplete and therefore clinically inadequate
• Right-based reductionism denigrates the profession and reduces obstetricians to mere technicians
• Rights-based reductionism in obstetric ethics is unprofessional

Engel G 1960; Chervenak FA, McCullough LB, Brent RL 2011
The Viable Fetus as a Patient

• Viability depends on both biological and technological factors

• No world-wide, uniform gestational age to define viability

Chervenak FA, McCullough LB, J Perinat Med 1997;25:418-20
The Pre-Viable Fetus as a Patient

• The woman’s autonomy provides link between fetus and child

• In vitro embryo is a subset of the pre-viable fetus
Obligations to Pregnant & Fetal Patients

- Beneficence-based obligations to a fetal patient must in all cases be balanced against beneficence-based and autonomy-based obligations to the pregnant woman
When the Fetus Is a Patient

- When the evidence is conclusive, counseling should be directive in the form of strong recommendation.
When the Fetus Is Not a Patient

• Non-directive counseling for fetal benefit is appropriate
Ethically Justified Framework

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Selective Termination

• In uncomplicated twin pregnancies, selective termination should not be routinely offered.

• In uncomplicated twin pregnancies, selective termination should be offered if the pregnant woman expresses concern about having two children rather than one.

• Non-directive counseling

Selective Termination

- In higher order pregnancies, selective termination should be routinely offered with the best available evidence
- Counseling should be non-directive

Selective Termination

- In multiple pregnancies complicated by fetal anomalies, selective termination should be routinely offered with the best available evidence
- Non-directive counseling

Double Effect

Clinical Interventions

Good Outcome

Bad Outcome
Double Effect

Clinical Intervention

Bad Means

Good Outcome
Ethically Justified Framework

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TTS is diagnosed

Expert evaluation with staging

Discussion of Prognosis with & without therapy

Termination of pregnancy

Continuation of pregnancy

Non-directive counseling about selective termination option

Selective termination

Directive counseling regarding which fetus is to be targeted

Other treatment options

Directive & non-directive counseling regarding treatment

Non-directive counseling regarding relevant available clinical trails

Skupski D, Chervenak FA, McCullough L. Fetal Diagn Ther 2007
Ethically Justified Framework

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Discordant Obligations

- Almost always, beneficence-based obligations to fetal patients in a multiple pregnancy are concordant.
- Rarely, they are discordant:
  - Benefit to one fetal patient will come at cost of iatrogenic harm to another fetal patient.
  - This usually takes the form of premature delivery for fetal distress.
Discordant Obligations

• In such clinical circumstances, the perinatal team must balance the risks of iatrogenic prematurity to the unaffected fetal patient against risks of non-delivery to affected fetal patient

• This balancing should be case specific
Discordant Obligations

• In cases of medical uncertainty, the informed consent process should be utilized to include the pregnant woman in the decision-making process

• Involvement of neonatology is essential for an adequate informed consent process
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