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A Proposal for Respecting Modesty in Ethical Considerations of Fetal Patients

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Abstract

Ethics consultations provide a structured avenue for sharing responsibility in complex decision-making scenarios in prenatal medicine, particularly when moral instincts alone cannot yield a clear course of action. Nevertheless, it remains uncertain whether the conventional frameworks for ethics consultation are fully applicable to the uniquely sensitive context of pregnancy. This study examines the distinctive types of disagreements, ethical conflicts, and value uncertainties that arise in prenatal care, and explores how an ethics consultation service (ECS) might address these challenges, illustrated through a case study. Currently, there is no widely accepted normative framework guiding ethics facilitation or conflict mediation in areas such as prenatal diagnostics, therapeutic interventions, or reproductive choice. Despite this gap, these tools can still support ethically difficult decision-making in prenatal medicine, provided that ECSs adhere to two provisional principles: (a) they should avoid issuing prescriptive, content-heavy recommendations in prenatal cases, and (b) they should refrain from initiating mediations involving the pregnant woman or couple as active parties in the conflict.

It is crucial for both ethics consultants and healthcare professionals to recognize the inherent limitations of current ethics consultation practices in prenatal medicine. Collaborative efforts are needed to develop robust standards tailored to the complexities of this field.

Keywords: Modesty, Ethical considerations, Fetal patients, ECS, Ethics facilitation

Introduction

Ethics consultation in pregnancy

Prenatal and maternal–fetal medicine is marked by ethically complex situations, intensified by the potential for pregnancy termination and the expanding array of available diagnostic and therapeutic options. Given this context, ethics consultation services (ECSs) play a critical role. While systematic data on the frequency and initiators of ethics consultations in prenatal care are limited, anecdotal evidence from single-center studies indicates that cases involving pregnancy—particularly requests for termination—frequently prompt ethics referrals [1–4].

In some healthcare settings, ECSs are required to participate in all decision-making related to late-term pregnancy termination [5], and certain services have been specifically established to support prenatal diagnostics and selective terminations [6, 7]. Ethics consultations are thus seen as opportunities to share responsibility in complex prenatal decisions, where moral intuitions may not provide definitive guidance. Yet, questions remain: Is prenatal medicine merely another domain for ethics consultation, akin to end-of-life care or psychiatric practice? Can standard ethics consultation procedures be directly applied to the intricacies of pregnancy? What should clinicians realistically expect from an ECS in this context?

To illustrate these unique ethical challenges and the role of facilitation-based ECS interventions, we present the following case study.

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Case example

A neonatologist, engaged in fetal medicine, requested an ECS review for a case in which a fetus was identified via ultrasound with multiple severe malformations, likely resulting from a chromosomal anomaly such as an autosomal trisomy. The prognosis indicated that the infant's survival would be extremely limited, potentially lasting only hours or, at most, a few days.

The neonatologist sought ethics input regarding the performance of an amniocentesis at 24 weeks' gestation, aiming to establish a cytogenetic diagnosis. Her intention was to justify providing only supportive care rather than full resuscitation at birth. The parents, having considered their baby's condition, expressed a preference for natural birth and palliative care without intensive resuscitation. The clinical team, however, indicated they would feel obligated to undertake full resuscitation unless the parents consented to the amniocentesis.

The ECS was consulted in the hope of resolving the disagreement between the clinical team and the parents. Implicit in the referral was the neonatologist's hope that ethics consultation might influence the parents to consent to the amniocentesis, which could potentially confirm a chromosomal anomaly. The underlying concern was that, without such confirmation, medical and nursing staff might insist on futile full resuscitation attempts, an outcome that no party actively desired.

The method of ethics consultation

Ethics consultation services (ECSs) are typically provided either by individual consultants or by committee members who respond to requests for guidance [8, 9]. These requests often arise when healthcare professionals, patients, or relatives encounter uncertainty or conflict in clinical decision-making, particularly regarding ethical values or norms.

In the case example presented, the disagreement between the clinical team and the couple over the ethical acceptability of an invasive procedure (amniocentesis) led to the involvement of the ECS. In such contexts, ECSs are expected to "enhance the quality of healthcare by identifying, analyzing, and resolving ethical questions or concerns" [8]. Nonetheless, significant debate remains concerning both the goals of ethics consultation and the appropriate individuals to provide it [10, 11].

The practice and theory of ethics consultation have historically been divided into two main models: the clinical (consultation) model and the facilitation/mediation model [12]. The clinical consultation model, established around forty years ago, involved consultants providing recommendations, offering advice, or suggesting specific courses of action [13, 14]. Consultants in this model acted similarly to other clinical experts, advising on the ethically preferable solution to a conflict.

In contrast, the contemporary ethics facilitation model—endorsed by the American Society for Bioethics and Humanities as a preferred approach [8]—focuses on achieving a "principled ethical resolution" [15] in situations of value uncertainty or conflict. Here, the ECS primarily functions to support decision-making and mediate between conflicting parties, rather than issuing prescriptive recommendations. While providing recommendations remains possible [8, 15, 16], it is not the primary role of the ECS. In the following sections, we focus on the facilitation approach when examining the processes and challenges of ethics consultation in prenatal medicine, while also considering its relevance to the clinical consultation model.

In ethics facilitation, ECSs generally support requesting parties in three key areas [8, 15]:

1. Understanding the ethical dimensions of the value uncertainty or conflict, including both expressed and latent interests of all parties.
2. Defining the spectrum of ethically acceptable options.
3. Resolving the conflict effectively.

Understanding the ethical nature of value uncertainties and conflicts in prenatal medicine

Prenatal medicine introduces unique circumstances for ECSs. Unlike typical clinical settings, pregnancy is not inherently a disease state, and conventional physician–patient role concepts may not fully apply. Clinical interventions in prenatal care simultaneously affect both the pregnant woman and the embryo or fetus. Some services aim to prevent or detect maternal conditions that may rapidly transform her into a patient, while many interventions primarily target the health of the fetus. Certain fetal treatments even expose the pregnant woman to risks in order to benefit the fetus. Furthermore, prenatal care often extends beyond health outcomes to support reproductive choice, impacting both the woman and the fetus.

In our case example, the focus was on the fetus's (or future child's) health, which drove the neonatologist's desire to confirm a diagnosis and prognosis before agreeing to palliative care. The healthcare team's concern

with protecting the decision-making process and mitigating potential liability added another layer of ethical consideration. Conversely, the pregnant woman's interests—avoiding invasive procedures, limiting her own emotional or physical burden, and opting for palliative care for her child regardless of genetic findings—were given comparatively less weight. Ethically, the professional discussion emphasized beneficence and non-maleficence toward the fetus, while the woman's reproductive autonomy and well-being appeared secondary.

In summary, prenatal medicine presents distinct ethical challenges compared to typical clinical settings such as end-of-life care. The strong physical and emotional connection between the pregnant woman and the fetus can create situations where their rights or interests appear to conflict. ECSs, as neutral and newly introduced agents, can play a crucial role in identifying and balancing both explicit and implicit interests, assessing their ethical relevance, and guiding the resolution of conflicts. This raises the central question: How can ECSs facilitate ethical resolution in the complex environment of prenatal medicine, and what can clinicians realistically expect from their involvement?

Defining a principled resolution

A central function of ethics facilitation is to delineate the spectrum of ethically defensible—or "principled"—solutions to a given dilemma. Ideally, this spectrum is informed by established ethical principles, legal requirements, and moral norms articulated through ethical discourse, legislative frameworks, and judicial decisions [15]. In prenatal medicine, however, there is no universally agreed-upon set of principles or arguments to guide such decisions [17]. The field remains characterized by intense and unresolved debates on foundational issues, including the moral status of the fetus [18], questions of justice [19, 20], and concerns about discrimination in prenatal testing [21].

To circumvent these contentious debates, efforts have been made to construct a normative framework for prenatal medicine that does not hinge on claims about the fetus's moral status. In the 1980s, McCullough and Chervenak proposed that healthcare professionals could regard fetuses as patients when presented as such by the pregnant woman, thereby assigning the fetus a dependent moral status with associated beneficence-based (rather than rights-based) duties [22]. However, the applicability and coherence of this concept remain widely debated [23–25]. The authors emphasized that treating the fetus as a patient does not necessitate seeing it as separate from the pregnant woman, nor does it entail granting it independent moral status [26]. Yet for many readers, the term "patient" inherently implies separateness and independent moral standing [24]. This tension creates a fundamental contradiction within the McCullough–Chervenak framework that remains unresolved.

The so-called "pragmatic concept" [26]—assigning the fetus a dependent moral status that becomes increasingly relevant with gestational age—may align with the moral intuitions of clinicians and the public. The more challenging issue, however, is grounding this status in the social role of "patient." As Lyerly and colleagues note, the paradigmatic patient is understood as a physically distinct, individuated entity, and medicine is historically oriented toward examining, diagnosing, and treating such patients [24]. Critics argue that labeling the fetus as a patient risks undermining the moral and legal rights of the pregnant woman, reducing her role to that of an "environment" for the fetus, a mere means rather than an end in herself [27–29].

If it were possible to conceptualize the fetus's dependent moral status differently—such as in terms of the future child's interests or rights—without assigning it a patient role, this could provide a more coherent normative basis for prenatal medicine. Currently, however, no universally accepted framework for physician–patient interactions or professional conduct in prenatal care exists [28, 30].

In the case example discussed, the ECS lacked any definitive guidelines to navigate the conflicting interests of the pregnant woman and the future child. According to Chervenak and McCullough, gestational age (viability) and the presence of medically effective interventions determine whether a physician has beneficence-based obligations toward the fetus or future child [22]. Even if such duties exist, they must be balanced against obligations of beneficence and respect for autonomy toward the pregnant woman. Under this framework, compelling or pressuring the woman to undergo an amniocentesis would be ethically questionable.

Alternative approaches that center the pregnant woman's interests, viewing fetal considerations as integral to maternal interests [28], may reject independent beneficence-based obligations to the fetus, thereby narrowing the range of ethically acceptable interventions. Additionally, the ethical significance of a future child's informational rights—especially in the context of broad

prenatal genomic testing—remains unsettled, as such testing could conflict with the child's potential right not to know certain genetic information while also intersecting with maternal or parental interests [17].

Overall, ECSs should explicitly acknowledge the current ambiguity and variability of ethical frameworks in prenatal medicine. In collaboration with clinicians, they must carefully examine and weigh different approaches relative to the specific consultation. Without a broadly accepted normative foundation, any content-heavy recommendation or directive from an ECS risks being perceived as arbitrary and should therefore be avoided.

Defining a principled resolution: The special case of reproductive choice

When prenatal medicine focuses not on prevention or therapeutic intervention—as in the case example—but on reproductive choice, the ethical complexity increases substantially. For instance, prenatal diagnostic tests for fetal aneuploidies are often performed to provide the pregnant woman with information that can guide her reproductive decisions, without offering any possibility of preventing or treating the chromosomal condition. In this context, decision-making closely resembles predictive testing for hereditary diseases, where the individual at risk serves as the primary decision-maker and considerations of beneficence are of limited relevance. Similarly, the core decision in many prenatal interventions revolves around the private deliberations of the pregnant woman or couple: essentially, "Given our desire for a child, do we want this particular child?" While medical information informs this process, the physician's ethical responsibilities beyond providing accurate information are minimal.

A parallel decision-making layer involves the healthcare professionals, raising ethical questions about the clinician's role—for example, whether to offer a specific prenatal test when its outcome may primarily serve the woman's reproductive choices and could potentially lead to termination of the pregnancy.

Ethics consultations can significantly influence both the private decision-making of the pregnant woman and the professional responsibilities of clinicians. Evidence from case series illustrates the weight of these interventions: in a Swiss study on obstetric ethics consultations, recommendations did not support the requests of pregnant women or couples in nine of 15 termination-related cases [4]. Similarly, in a German series, ECSs advised against late-term pregnancy terminations in four out of 13 requests, citing ethical concerns [5]. The underlying criteria for these recommendations are often opaque.

The ethical landscape in these situations is complicated by multiple "patients" and competing objectives—primarily reproductive autonomy versus the potential termination of pregnancy. If respecting and enabling reproductive autonomy is a central aim of clinical practice in this field, it raises profound questions about the legitimacy of ECS interventions that override the woman's choices. Are case-by-case recommendations sufficient to address the moral dilemmas associated with pregnancy termination, or would comprehensive, standardized guidelines provide a more consistent and ethically defensible approach? These questions are essential for developing a rigorous theoretical foundation for ethics consultations concerning reproductive choice. Until such a foundation is established, the role of ECSs in these scenarios remains inherently constrained.

Resolving: Conflict mediation in prenatal medicine

When conflicts arise, an ECS aims to facilitate dialogue among all relevant parties, ensuring that "each and every voice is adequately heard and protected" [15], with the ultimate goal of fostering consensus between conflicting stakeholders. In prenatal cases, the perspectives of the pregnant woman or the couple are unquestionably central and must be incorporated at some stage of the process. A critical challenge, however, is determining how the interests of the fetus—and particularly the potential future child—should be represented, even if one considers fetal welfare as inherently tied to maternal interests.

Even without engaging in debates about fetal or embryonic rights to life, numerous scenarios exist in which medical decisions directly affect the future child. For example, prenatal investigations or interventions may generate information or cause outcomes that could adversely impact the child's future well-being. With the rapid expansion of diagnostic and therapeutic options—such as fetal whole genome sequencing or non-invasive prenatal testing [30]—a facilitation process that does not consider the potential impact on the future child may be incomplete.

One might argue that this is analogous to situations where patients are too unwell to participate in decision-making. In such cases, clinicians and relatives work together to represent the patient's preferences, making the "phantom" patient's interests tangible [15]. Surrogates

and advance directives are established mechanisms to address this. The challenge in prenatal medicine is that the future child has no developed preferences, and the pregnant woman—who is also a patient—is physically and emotionally intertwined with the fetus. Unlike conventional surrogate arrangements, the woman cannot be treated as a proxy solely for the fetus, nor is it generally acceptable to introduce a third party (e.g., specialist, ethicist, social worker, or court) to act as a surrogate for the fetus or future child, given the intimate maternal–fetal connection.

In the case example, the pregnant woman and her partner can naturally serve as representatives for their fetus and future child, as the primary ethical concern is the child's welfare. The planned amniocentesis carries minimal risk to the woman's health, suggesting that her personal conflict of interest is limited at this stage. Nevertheless, preparatory discussions with the ECS may reveal deeper anxieties related to raising a severely disabled child with a short life expectancy, introducing an internal "pregnancy conflict" that could influence their preference for palliative care.

While the couple can act as the primary representatives of fetal and future child interests, there are circumstances where this responsibility may become overwhelming—particularly when internal conflicts exist. In such cases, joint mediation sessions with the clinical team could impose excessive stress and may not yield a constructive outcome. Alternatively, a series of smaller, private meetings with the pregnant woman or couple can help clarify internal conflicts, establish their priorities, and create a foundation for ethically sound conflict resolution.

Conclusion

In the context of prenatal diagnosis and therapy, the primary responsibility of any ECS is to recognize its current limitations and actively contribute to refining the theoretical foundations of ethics consultation. Pregnancy presents unique ethical challenges that differ substantially from other areas of clinical practice. Applying general ethics consultation standards without careful reflection carries significant risks for all parties involved—the pregnant woman or couple, the fetus or future child, and the healthcare professionals.

An ECS adopting a facilitation approach should transparently communicate the uncertainty and variability of ethical concepts in prenatal medicine and refrain from offering prescriptive, content-heavy recommendations, particularly in cases involving reproductive choice. When there are indications of an internal conflict within the pregnant woman regarding the pregnancy, conducting smaller, focused meetings with her or the couple should precede any larger, joint mediation sessions.

Clinicians play a crucial role in this process. Their firsthand experience with everyday ethical dilemmas is indispensable for bridging professional ethical principles with moral intuitions, thereby helping to develop a comprehensive normative framework for this complex domain. For instance, if prevailing intuitions about fetal "patienthood" conflict with general moral principles or the reproductive rights of the pregnant woman, interdisciplinary collaboration may enable the creation of a more ethically coherent approach.

Until a robust and widely accepted normative framework for prenatal medicine is established, ECSs should proceed cautiously, emphasizing understanding, acting as a reflective sounding board, and fostering Socratic dialogue. This approach ensures that their involvement remains constructive, practical, and ethically responsible.

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