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A Critique of the 'Fetus as Patient'

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Reasoning about the fetus is a complex, often vexing, challenge. Indeed, at the center of the some of the most provocative and difficult bioethical debates in the last decade are questions about the responsibilities of society, physicians, policymakers, scientists, and pregnant women to embryos and fetuses. Having noted the problems particular to use of the pervasive term 'unborn child,' McCullough and Chervenak propose 'patient' as a clarifying alternative for discourse about the fetus (McCullough and Chervenak 2008), at least for questions in the realm of clinical medicine. According to McCullough and Chervenak, shifting to this language avoids certain connotations brought by 'unborn child,' helpfully highlighting, for instance, the beneficence- rather than rights-based nature of obligations toward early life, as well as what they call the "dependent status" of that life. While we concur with McCullough and Chervenak in rejecting the language of unborn child, we have concerns that the alternative they propose brings dangers of its own.

Certainly for pregnancies that are going to be continued, medical professionals have beneficence-based obligations to fetuses not merely derivative of the concerns of their pregnant patients. Central to obstetrical practice in such pregnancies are efforts to prevent, diagnose and treat conditions before birth: nutritional supplementation to prevent birth defects; ultrasonography and invasive testing to detect chromosomal and other fetal conditions; and pharmacologic and surgical intervention to address a range of prenatally identified illnesses. All are means that feel integral to the professional duties of physicians, nurses, and allied health providers toward their patients. It is no wonder, then, that those who provide care for and theorize about fetuses seek – and find comfort in – a familiar term to describe this entity to which they have responsibilities and for which they care. But analogous to the authors' critique of 'unborn child,' we believe the term 'patient' is also – if more subtly – misleading. Two worries in particular are introduced by the discourse of fetal patienthood.

First is the worry that such a designation may encourage a tendency to think of the fetus as separate from the pregnant woman (Lyerly and Mahowald 2003), obscuring the physical and social relationship between pregnant woman and fetus, the ways that maternal and fetal physiologies and welfare are linked, and perhaps most problematically, the woman herself.

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Peer Commentary on: A Critical Analysis of the Concept and Discourse of 'Unborn Child' (McCullough and Chervenak, AJOB)

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The *paradigmatic* patient is an entity physically individuated and fully separate from others. It is against this broad backdrop that those in medicine think about examining, diagnosing, and treating patients. It is also against this broad backdrop that we rightfully – and helpfully – think about causal determinants of health and illness outside the body as influences of the environment, which we can affect and manipulate to achieve therapeutic goals. Applied to a "patient" that is physiologically enmeshed with another – whose "environment" is the body of an autonomous agent, the designation of 'patient' may make it easier to think about the pregnant woman herself as an environment rather than a patient in her own right.

Certainly, referring to the fetus as a patient will not incline all clinicians to this way of thinking. Yet practitioners, cultural historians and others have raised concern at the language fetal surgeons and some obstetricians use to describe the women through whom they diagnose and treat the fetus: the "uterine environment," the "recovery room" a "natural incubator" for the fetus (Casper 1998) – or worse, reduced to a holding cell that entraps the fetus (Taylor 1997), her abdominal wall a "a fortress against fetal health care"(Phelan 1991). What at first glance seems merely to be a semantic offense may give rise to substantive concerns of real consequence to the well being of pregnant women. Trends in the reporting of surgical interventions for fetal conditions, for example, reflect a notable paucity of studies measuring short- and long-term outcomes for women who choose to participate in these innovative and highly invasive intrauterine procedures (Lyerly et al. 2001). Recent efforts to correct this myopia have identified significant maternal risks of pre-birth intervention, with nearly one in three women hospitalized until delivery, one in five developing pulmonary edema, and one in nine with an admission to an intensive care unit (Golombeck et al. 2006).

This concern is by now a familiar one, as is McCullough and Chervenak's response. The authors argue, in the present manuscript and elsewhere, that patienthood does not logically entail separateness: "the concept of fetus as patient," they emphasize, "does not require that the fetus be regarded as a separate patient." We agree. But to think this a response to the criticism is to misunderstand the nature of the concern, which has, in essence, to do with a distinction from the philosophy of language. As scholars in the field have emphasized, the content of a concept is given not just by its literal semantic content – its dictionary definition, or necessary entailments – but by the patterns of reasoning, conversational implicatures and interpretational proclivities that animate its use (Grice 1957; Brandom 1994). The former outline the contours of logical entailment; the latter, just as important, outline patterns of precedential and analogical reasoning, dominant metaphors, and interpretational guides. Our concern, then, is not that McCullough and Chervenak are logically committed to regarding the fetus as a separate entity, but with the danger of extending the concept of patient beyond the paradigmatic instances that form its animating core.

A similar point applies to our second worry. 'Patienthood,' as McCullough and Chervenak would agree, is a normative status that connotes concrete expectations for professional engagement: physicians are duty-bound to be fiduciaries of their patients. More specifically, physicians are typically understood as having a strong, primary, and equal fiduciary duty to their individual patients. This raises the concern that, insofar as clinicians regard themselves as having two patients – even two intertwined patients – they may regard their obligations to and the value of each of their patients as equal. Yet tragically, we face circumstances in the context of pregnancy that reflect how important it is to recognize the primacy of the clinician's duties to the pregnant woman. Consider the case of a woman with both a desired pregnancy and a cardiopulmonary anomaly associated with a 25–50% of maternal death with prolonged gestation and delivery (Weiss et al. 1998). Intensive medical management would reliably be expected to benefit the fetus; as its fiduciary, the physician would be bound to recommend continued pregnancy and aggressive medical management; pregnancy termination of a healthy and desired fetus would be an anathema. Yet as the pregnant woman's fiduciary, the physician

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would be bound to raise, even recommend, termination of an otherwise desired, perhaps beloved pregnancy.

This problem is not solved by appeal to the fetus's "dependent moral status." Such medical difficulties can and do arise even as the woman is planning – sometimes begging – to continue the pregnancy. Relative to the theory offered by McCullough and Chervenak, the fetus is, at the time of this wrenching discussion, a patient. Yet, it stretches the concept to the breaking point to categorize the fetus as a patient even as one counsels killing it for the sake, not of its own well-being (as in the examples the authors raise of what are in essence mercy killings in the face of a life not worth living), but for the continued well-being of another. The paradigm of normative asymmetry, vivid in both moral intuitions and American jurisprudence, is thus critically obscured by the notion of fetal patienthood.

Once again, McCullough and Chervenak might counter that the concept of patient does not *entail* primary or equal fiduciary duties; it is logically possible to regard the fetal patient as normatively asymmetrical to the pregnant woman patient, and 'patient' as a term that carries with it no fixed stringency of beneficence-based medical obligation. Once again, though, our concern is not with logical entailments but with the broader aspects of pragmatic meaning. If the word 'patient' were merely a technical term stipulated to mean an object of some unspecified beneficence-based medical obligation, then, with suitable qualifications, referring to the fetus as a patient could be rendered morally unproblematic. By the same token, however, if the term 'unborn child' could be reduced to a technical term with a specified meaning, it, too, could be rendered morally suitable. The reason to be concerned with the latter, despite the availability of dictionary definitions, is the same kind of reason to be concerned with the former: concepts have their own pragmatic lives, and what counts as an illuminating and helpful extension of a concept, rather than an obscuring or worrisome one, is in large part a function of how that extension comports with or battles the penumbral associations that inform the concept's broader meaning. The danger in calling the fetus a patient is found not in the logical fallacies that would follow, but with the proclivities of reasoning and interpretation, already natural to some, that it might underscore. This problem, note, is not unique to 'patient.' *None* of the usual concepts inherited from law, medicine, or philosophy – person, patient, child – were designed with the fetus in mind (Little 2003). Deploying any such off-the-shelf concepts, however many asterisks we add, risks distortion.

Everyone should agree that, for pregnancies that will be continued (as well as, in our opinion, for late gestational age fetuses), pregnant women and physicians alike have beneficence-based moral obligations toward the fetus. Progress in thinking morally about the nature of these obligations will come from exploring partial and overlapping analogies from a wide variety of situations in which clinicians have obligations to multiple objects of concern (i.e., parents, siblings) that extend beyond the discrete patient. Where such progress will not be found, we fear, is in adding qualifications to concepts whose pragmatic meanings are fundamentally formed around reflection on individuals who, physically separate and endowed with independent moral status, stand in stark contrast to the fetus.

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