Ethics of Fetal Surgery [1]

By: O'Connor, Kathleen

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1. Introduction

Surgeons sometimes operate on the developing fetuses in utero of pregnant women to treat a number of congenital abnormalities, operations that have ethical aspects. A. William Liley performed the first successful fetal surgery, a blood transfusion, in New Zealand in 1963 to counteract the effects of hemolytic anemia [6], or Rh disease, on a fetus [7]. The ethical discussions surrounding fetal surgery are complex and are still being defined, as fetal surgery represents an emerging field of in utero medical interventions that impact the quality of life for both pregnant women and fetuses. Such discussions involve the ethical relationships between parents, fetuses, doctors, and health care organizations like hospitals. What may benefit the fetus [7] may harm the pregnant woman, and what may benefit the pregnant woman could negatively impact the viability [8] of the pregnancy [9]. Risks to the pregnant woman include preterm membrane rupture, preterm labor, wound infection, hemorrhage, loss of uterine [10], damage to the organs near the uterus [10], and possibly death. Fetal surgery does not always improve the quality of life for the developing fetus [7], and the risks and benefits of fetal surgery must be weighed and discussed between the medical team, the pregnant woman, and her partner to customize the most ethical plan of action.

2. Fetal Surgery

Doctors currently use fetal surgery to drain blocked bladders, to repair heart valves, and to remove abnormal growths from fetal lungs. Two examples are as follows. Diaphragmatic hernias are one condition currently corrected by pre-neonate surgeons, whereby surgeons in utero repair the muscle that divides the abdominal and chest cavities of fetuses to facilitate proper fetal lung development. Surgeons have also succeeded in correcting myelomeningocele, a type of spina bifida [11], by closing the tissue over the fetus’s spinal cord in the affected area.

There are three basics types of fetal surgeries. The oldest type is the open hysterotomy, characterized by a surgical incision through the multiple layers of the uterus [10], including the maternal abdominal wall, uterus [10], and the membrane surrounding the fetus [7]. Hysterotomy is a technique developed by pediatric surgeons Alfred de Lorimier and Michael R. Harrison in the late 1970s and early 1980s at the University of California in San Francisco, California. The second type of fetal surgery involves fetoscopy, whereby a surgeon uses a fiber-optic endoscope and ultrasound [12] to view the fetus [7]. With advances in surgical instrumentation and the lightweight, high resolution capabilities of the fetoscope, there are many benefits with this procedure compared to the more invasive hysterotomy, and many fetal surgeries are now performed using this method. A fetoscopy incision is much smaller than open fetal surgery and is less traumatic to the pregnant woman’s uterine and abdominal walls, and it often lessens the likelihood of premature labor [13]. The third approach to fetal surgery, percutaneous fetal therapy, is the least invasive procedure and involves placing a catheter under continuous ultrasound [12] guidance into areas of the fetus [7] like the bladder or pleural space to drain excess accumulations of fluid.

Technological advances in neonatal intensive care units to treat premature births helped to advance the field of fetal surgery. Also integral are techniques to monitor the health of the pregnant woman post-surgery. Surgical intervention to correct a fetal anomaly is traumatic to a woman’s body, and post-operative care involves bed rest, medications, and hospital stays. Often, surgeons will simultaneously and continuously monitor both the fetus [7] and the woman postoperatively until the birth.

Fetal surgery is rare and the option exists for only a small number of pregnant women, as many conditions must be met before fetal surgery is considered a treatment option. Specialized surgical and medical teams involved in such high risk procedures practice in few centers world wide. Additionally, considerations such as the risks and benefits of surgery, the likelihood of favorable outcomes, and the costs of the initial and follow-up procedures, are factors in the consideration to offer pregnant women the option of fetal surgery. Surgery is usually performed on a fetus [7] only when the quality of life for the infant after gestation [14] would be drastically lessened without surgical intervention. That is, if no intervention were to occur, the fetus [7]...
Research on fetal surgeries often face further regulations. The surgeries to repair a malformation or to advance the life of a pregnant woman and the father. The pregnant woman has, as an autonomous individual, the right to decide not to pursue the result from rape or incest. The physician reviews the procedure, its benefits, and risks in the form of surgery will not be performed. In the US, federal regulations also require the consent of the father for fetal surgery and fetal viability. In many developed countries' healthcare laws, a pregnant woman must consent to an intervention that involves the invasiveness of fetal surgery to the pregnant woman can detrimentally impact the viability for both pregnant woman and fetus. At any time prior to outcome for the woman and to the fetus. At any time prior to gestation occurs at about Week 24 of gestational age. At just over 24 weeks gestation, the fetus can be sustained and grow with technological support outside the uterus. Prior to viability, the fetus cannot be sustained ex utero, and the moral status of the fetus is determined by the pregnant woman, based on her autonomy. It is not until the fetus is a patient that the physician has beneficence-based obligations to protect its life and health.

Ethical obligations to patients often involve a beneficence-based approach to care, one where the intention is to benefit the patient. Obligations to the fetus may exist when the potential for a positive medical outcome is greater than the risk of harm in therapeutic intervention. Patienthood at times applies to the unborn fetus, when a fetus with congenital anomalies may be amenable to fetal surgery, but the fetus is not autonomous. Furthermore, beneficence for the fetus does not necessarily allow for nonmaleficence for the pregnant woman. For some, the pressure to do everything possible to save the fetus, or to reduce or minimize anomalies, may be enough to weigh the minimal possible advantages to the fetus over the maximum risks to the woman and to the fetus, even though the surgery may risk the pregnant woman’s life without guaranteeing a successful outcome for the fetus.

At the same time there are the beneficence-based and autonomy-based obligations to the pregnant woman. At any time prior to viability, the pregnant woman may withdraw patient status of the fetus even after giving the fetus this status. The invasiveness of fetal surgery to the pregnant woman can detrimentally impact the competence of her uterus for the current pregnancy and for future pregnancies. Additionally, fetuses that die due to fetal surgery that a pregnant woman consented to may cause her more grief than would death resulting from the congenital anomaly in question.

4. Regulations and Oversight Groups

In many developed countries’ healthcare laws, a pregnant woman must consent to an intervention that involves the fetus, or the surgery will not be performed. In the US, federal regulations also require the consent of the father for fetal surgery and fetal research unless he is unable to consent because of unavailability, incompetence, temporary incapacity, or the pregnancy resulted from rape or incest. The physician reviews the procedure, its benefits, and risks in the form of informed consent to the pregnant woman and the father. The pregnant woman has, as an autonomous individual, the right to decide not to pursue the intervention.

Research on fetal surgeries often face further regulations. The surgeries to repair a malformation or to advance the life of a fetus.
Sources


5. Harrison, Michael R., Nancy Ross, Rhoda Noall, and Alfred A. de Lorimier. “Correction of congenital hydronephrosis in
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