Winter 2011

Philosophy and Theology: Notes on Fetal Interventions

Christopher Kaczor
Loyola Marymount University, Christopher.Kaczor@lmu.edu

Philosophy and Theology

The ethics of fetal surgery raises numerous questions. In this reflection, I would like to consider only three of them. Is the fetal human being a "patient" and, if so, under what conditions? Why does the "reduction" of a twin pregnancy to one baby cause such difficulty for defenders of abortion? Is it morally permissible to prevent a dying fetal twin from bringing about the death or serious injury of a healthy fetal twin by means of umbilical cord occlusion?

Arguably the most prominent scholars exploring the ethical questions about fetal surgery are Frank A. Chervenak and Laurence B. McCullough. In a series of books and articles, they have established themselves as the foremost authorities in the area. How do they answer the first and fundamental question about fetal dignity? Chervenak and McCullough point out that there has been a long-standing debate about whether or not the human fetus has independent moral status ("Ethics of Fetal Surgery," *Clinics in Perinatology*, June 2009). As in many other debates, there has never been a definitive answer to the question that settles the matter once and for all to the satisfaction of all parties. Those in a given theological tradition disagree with those in others and often disagree among themselves as well. In a similar way, philosophy offers many different methodologies which lead to different conclusions about the issue, so reasonable people still disagree about whether the fetal human being should be accorded basic human rights.[1] So Chervenak and McCullough hold that the only rational course of action is to abandon the debate about whether or not the human fetus is a patient with independent moral status, and to pursue a question that they think is answerable, namely, whether the fetal human being has dependent moral status. In "Ethics of Fetal Surgery" they write, "A philosophically more sound and clinically more useful line of ethical reasoning is that the moral status of the fetus depends on whether it is reliably expected later to achieve the relatively

[1] Laurence B. McCullough and Frank A. Chervenak, *Ethics in Obstetrics and Gynecology* (New York: Oxford University Press, 1994): 97–101.

unambiguous moral status of becoming a child and, still later, the more unambiguous moral status of becoming a person. This is called the dependent moral status of the fetus." On McCullough and Chervenak's view, the human being in utero has dignity when viable and when the pregnant woman presents herself to the doctor in order to secure help for the human fetus.

This proposal to shelve the debate about the independent worth and focus on dependent status fails for a number of reasons. First, the view of McCullough and Chervenak is self-defeating. They themselves presuppose a particular methodology, a methodology that is not universally accepted. So if we ought to abandon projects that do not make use of a universally accepted methodology, they too should abandon their project.

Second, the McCullough–Chervenak position rests on feigned neutrality. It is possible to be agnostic in theory about the value of human life in utero, but it is not possible to be agnostic in practice when one is treating fetal human beings. A physician treating a pregnant woman must either act as if the human being in utero is a second patient with independent worth or not. It is grossly irresponsible to "shelve" the question of the moral status of the fetal human being because a physician treating a pregnant patient who has asked for medical action affecting the unborn must act in one way or the other. If the physician harms the fetal human being, he or she gives a practical answer (whatever the theoretical stance) that the human fetus has no independent value.

McCullough and Chervenak assert that the fetal human being has dependent status when and only when he or she is viable *and* the pregnant woman presents herself to the physician and asks for treatment for her unborn child. McCullough and Chervenak present no argument for the importance of viability for moral worth. The thesis is simply asserted, the definition of viability is explained a bit, and the conclusion is reasserted.

However, viability is irrelevant to moral status. In cases of conjoined twins, one twin may be physiologically dependent on another, and yet no one questions whether conjoined twins have equal basic dignity to other persons. Furthermore, viability varies according to access to technology, but it is absurd to say that the moral worth (even the dependent moral worth) of a person varies according to the person's location—that is, whether the person is near a hospital or far away.[2] The ability to live in one location rather than another is irrelevant to moral status.

McCullough and Chervenak do give an argument for why the decision of the woman is relevant to whether or not the fetus is a patient, namely, that independent moral status arises later and will not be possible without the decision of the woman to continue the pregnancy: "This is because the only link between a previable fetus and its later achieving moral status as a child, and then a person, is the pregnant woman's autonomy, exercised in the decision not to terminate her pregnancy, because technologic factors do not exist that can sustain the previable fetus ex utero. When the

[2] For more on this topic, see section 4.1.2 of my book *The Ethics of Abortion: Women's Rights, Human Life, and the Question of Justice* (New York: Routledge, 2011).

pregnant woman decides not to terminate her pregnancy and when the previable fetus and pregnant woman are presented to the physician, the previable fetus is a patient."

This argument is unsound. It is false that the only link between a previable fetus and its later achievement of moral status is the choice of the woman. If by "link" they mean a necessary (but not sufficient) condition, they are correct that a necessary condition for a child's reaching the age of two is that the mother does not abort him or her, but they are incorrect in claiming that this is the *only* condition. Other links, understood in this sense, include that the child does not die of natural causes prior to two years of age, that the child is not killed shortly after birth, and that a forced abortion is not performed, among many others. If we understand the "link" of a woman's choice not to have an abortion as a sufficient condition, similar problems arise. Since Chervenak and McCollough's argument rests on a false premise, it does not justify their conclusion.

Chervenak and McCollough's treatment of fetal surgery is flawed in other ways as well. They write,

> To protect the woman from being coerced, her husband or partner and other family members should be reminded that although they may have strong views for or against her participation, their role should be to support and respect the woman's decision-making process and its outcome. Their relationship to her is primarily one of obligation to respect and support her decision. Family members do not have the right to make decisions for her. When necessary, this aspect of the informed consent process should be made clear to family members. Clinical investigators should ensure that everyone involved in the consent process takes a strictly nondirective approach. Although not currently required in federal consent regulations, prospective monitoring of the consent process (eg, in random sampling) could be used to enforce the nondirective approach.

Chervenak and McCollough offer no justification for any of these controversial claims. It is true in current U.S. law that the woman has the legal right to make the decision to abort. Whether or not she also has the moral right to fetal homicide (as performed in a pregnancy "reduction") remains a topic of vigorous disagreement. Legally, there is no obligation whatsoever for family members or anyone else for that matter to refrain from voicing their opinions about her contemplated choice as much as they like. At least in the United States, the first amendment of the Constitution protects free-speech rights, which are not rescinded in family relationships or when one takes the Hippocratic Oath. In ethical terms, there is simply no obligation "to support and respect" someone else's decision, whatever that decision may be. If a decision is an ethically permissible or commendable one, then it should be respected and supported. If a decision is an ethically impermissible one, it should be neither respected nor supported. The *person* who makes the decision should be respected and supported, as is appropriate for all persons with dignity, but not the *decision* itself. Clear-headed people have no obligation to support and respect ethically wrong decisions, such as the decision to drive under the influence. Love and respect for others, including the potential drunk driver, demands that we seek ways to help them avoid wrongful choices, including in many circumstances trying to talk them out of it.

On a positive note, Chervenak and McCollough are correct in noting how fetal homicide impedes scientific research: "From the perspective of investigators, to obtain

the cleanest results about outcomes for fetuses and future children, one would not want any pregnancies in which fetal surgery occurred to result in elective abortions." In his article "Fetal Therapy: Practical Ethical Considerations," Yves Ville makes the same observation: "Owing to the high incidence of TOP [termination of pregnancy] following prenatal diagnosis of these conditions, comparative studies are going to be difficult to perform" (*Prenatal Diagnosis*, July 2011).

In this discussion, TOP is a favored term, but this is unfortunate, because "termination of pregnancy" (TOP) is ambiguous and euphemistic. It is ambiguous because vaginal birth, cesarean section, and spontaneous miscarriage also "terminate" a pregnancy and because abortion can take place in cases where no "termination of pregnancy" occurs, as in the fetal homicide of one twin when the other twin is left alive. The acronym TOP is euphemistic because, even more than the phrase "termination of pregnancy," it sounds benign, innocent, and noncontroversial. The reality is better conveyed by the more accurate, honest, and precise term "abortion."

Ville raises other ethical questions about fetal surgery. He notes a certain bias among practitioners for giving treatments, which may not be in the patient's best interest: "Offering treatment for a fetus demonstrating objective signs for an irreversibly poor outcome is questionable in that the benefit of treatment can be expected to be little if any and medical enthusiasm may also be strengthened with the view to improve one's own practice with the procedure." A surgeon's desire to strengthen surgical skills or pioneer new techniques may come into conflict with providing what is best for both patients.

Ville also claims that "prenatal diagnosis is the only field of medicine in which termination has a role in the management of a disease." This is false, because "termination" of a patient is not management of a disease. As Jorge Garcia points out in his judicious discussion of physician-assisted suicide, killing is not the relieving of pain. Garcia's reflections can be extended to also show that killing is not managing a disease:

> Ending [a patient's] pain cannot be a benefit to her for the usual reason, then, because [in physician-assisted suicide] the patient does not experience relief and thereafter live pain-free. As the end of her pain here does not improve her experience, neither does it improve her life, her condition. Rather, she (her integrated human life) ends along with the pain, and *she* is in no condition at all during the period when she is lifeless. We cannot, then, meaningfully compare it with her condition over the same time had she lived. … Thus, it is difficult to see just what benefit our killing renders her, as it *improves* neither her experience, nor her life, nor her condition.[3]

Just as killing people to relieve their pain is not pain relief, so too abortion is not management or cure of disease. Indeed, if we define disease as a lack of proper biological functioning to a greater or lesser degree, fetal killing induces the maximum of disease, complete nonfunctioning.

About fetal moral status Ville writes, "Although the concept of the fetal status gaining more independence from its mother with gestational age is universally accepted, its importance is to be balanced with other issues, including maternal safety

[3] J. L. A. Garcia, "The Doubling Undone? Double Effect in Recent Medical Ethics," *Philosophical Papers* 36.2 (2007): 245–270, original emphasis.

as well as the severity of the fetal condition." However, it is not universally accepted that fetal status is linked to gestational age such that the more physiologically developed the fetus becomes, the greater the value the fetal human being has. This gradualist or developmental view of the value of human life prior to birth is controversial and is rejected by many people on a variety of grounds. Obviously, those who oppose fetal homicide because all human life has equal basic value reject the view that fetal worth develops in the course of pregnancy.[4] But many of the most prominent supporters of abortion, such as Peter Singer, Michael Tooley, David Boonin, and Judith Jarvis Thomson, also reject this view. Ville offers no argument for this view, but simply assumes without justification that the developmental view is obviously true.

Indeed, Ville's view of fetal status is inconsistent. He writes,

> The issue of fetal analgesia touches on the surgical approach itself inasmuch as on the "primum non nocere" principle in all procedures invasive to the fetus itself. It is well established that very preterm neonates experience pain, and related autonomic neural connections function from around 22 weeks of gestation. It is therefore important that any directly invasive fetal procedure be preceded by appropriate fetal analgesia. … Practitioners who undertake termination of pregnancy at 24 weeks or later should also consider the requirements for fetal analgesia or sedation prior to feticide before inducing labor.

This approach surely does not work. If a fetal human being should not be harmed (*primum non nocere*), it is true that this principle requires the use of analgesia for operations in which the human being in utero may suffer, but a fortiori it is also true that the more significant harm of death should not be inflicted. The *primum non nocere* principle either applies to the unborn or it does not.

This disjunction is also apparent in twin pregnancies. The "reduction" of a pregnancy from twins to a single baby is controversial even among those who otherwise staunchly defend fetal homicide. Responding to a *New York Times Magazine* story by Ruth Padawer that raised the issue in public awareness, William Saletan's article in *Slate*, "Flaws in Pro-Choice Logic," puts the spotlight squarely on the problem for defenders of abortion.[5] Why should defenders be troubled by abortion that reduces twins to a single baby? They clearly are, but they have a difficult time articulating why. Saletan recognizes the schizophrenic thinking of many defenders of fetal homicide:

> Embryos fertilized for procreation are embryos; embryos cloned for research are "activated eggs." A fetus you want is a baby; a fetus you don't want is a pregnancy. Under federal law, anyone who injures or kills a "child in utero" during a violent crime gets the same punishment as if he had injured or killed "the unborn child's mother," but no such penalty applies to "an abortion for which the consent of the pregnant woman … has been obtained." Reduction destroys this distinction. It combines, in a single pregnancy, a wanted and an

[4] For a philosophical justification for the equal basic worth of all human beings, see my *Ethics of Abortion*; on the developmental view and why it is mistaken, see section 4.3. See too my article "Equal Rights, Unequal Wrongs," *First Things* 204 (August–September 2011): 21–23.

[5] Ruth Padawer, "The Two-Minus-One Pregnancy," *New York Times Magazine*, August 10, 2011, http://www.nytimes.com/2011/08/14/magazine/the-two-minus-one-pregnancy.html. William Saletan, "Flaws in Pro-Choice Logic," *National Post*, August 17, 2011, http://fullcomment.nationalpost.com/2011/08/17/william-saletan-the-flaws-in-pro-choice-logic/.

> unwanted fetus. In the case of identical twins, even their genomes are indistinguishable. You can't pretend that one is precious and the other is just tissue.

Killing one twin in utero while letting the other live brings into full consciousness the doublethink that is usually merely implicit, revealing no minor cognitive dissonance.

One final question about fetal surgery is the ethics of umbilical *cord occlusion* in cases of twin–twin transference syndrome.[6] In such cases, the twins are connected by a shared placenta. One of the twins is dying (from imminent, irreversible cardiac failure, for example), but the other twin is healthy. When the first twin dies, the other twin has a high risk of death or permanent, serious neurological injury.

Is it morally permissible to perform umbilical cord occlusion to prevent the dying twin from bringing about the death or serious injury of the healthy twin? Umbilical cord occlusion cuts off the circulatory link between the twins, preventing the dying twin from harming the healthy twin, but at the same time it cuts off the life-supporting link of the dying twin to the placenta. The one action brings about two effects, one good and the other bad. In terms of double-effect reasoning, the question in part is the following: Is umbilical cord occlusion selective feticide or is it the foreseen but not intended death of one twin to save the other twin?

Supposing for the sake of argument that the death of the weaker twin is not desired as a means or an end in itself, and that the fourth condition of double-effect reasoning is met, namely, that there is a just cause for allowing the evil effect. My view is that the justification or condemnation of umbilical cord occlusion depends on how one understands the distinction between intended effects and merely foreseen effects. If all the certain or simultaneous effects of the action are intended, then according to double-effect reasoning, it is impermissible to bring about the negative effect—specifically, fetal demise following umbilical cord occlusion. Although others would disagree with me, it is my opinion, however, that if the intended effects are understood to be limited to what is chosen as a means or an end, as part of the plan, or as desired effects,[7] then umbilical cord occlusion would be permissible according to double-effect reasoning, despite its certain and simultaneous negative effect of accelerating the death of the dying twin. It is permissible to not prevent the foreseen death of one person in order to save the life of another.

Fetal surgery doubtless gives rise to other ethical issues as well, but twin–twin transfusion syndrome is among the most difficult. Without a cogent answer to the questions of fetal dignity and reduction of pregnancy, the likelihood of coming to a just solution in cases of twin–twin transfusion syndrome is remote.

Christopher Kaczor

---

[6]For the medical background, see, for example, Ramen H. Chmait and Ruben A. Quintero, "Operative Fetoscopy in Complicated Monochorionic Twins: Current Status and Future Direction," *Current Opinion in Obstetrics and Gynecology* 20.2 (April 2008): 169–174; and A. Cristina Rossi and Vincenzo D'Addario, "Umbilical Cord Occlusion for Selective Feticide in Complicated Monochorionic Twins: A Systematic Review of Literature," *American Journal of Obstetrics and Gynecology* 200.2 (February 2009): 123–129.

[7]See, for example, John Finnis, Germain Grisez, and Joseph Boyle, "'Direct' and 'Indirect': A Reply to Critics of Our Action Theory," *The Thomist* 65.1 (January 2001): 1–44.

Journals in Philosophy and Theology

Bioethics

Volume 25, Number 4
May 2011

The Virtue Ethics Approach to Bioethics

S. Holland

This paper discusses the viability of a virtue-based approach to bioethics. Virtue ethics is clearly appropriate to addressing issues of professional character and conduct. But another major remit of bioethics is to evaluate the ethics of biomedical procedures in order to recommend regulatory policy. How appropriate is the virtue ethics approach to fulfilling this remit? The first part of this paper characterizes the methodology problem in bioethics in terms of diversity, and shows that virtue ethics does not simply restate this problem in its own terms. However, fatal objections to the way the virtue ethics approach is typically taken in bioethics literature are presented in the second section of the paper. In the third part, a virtue-based approach to bioethics that avoids the shortcomings of the typical one is introduced and shown to be *prima facie* plausible. The upshot is an inviting new direction for research into bioethics' methodology.

Volume 25, Number 5
June 2011

The Dead Donor Rule, Voluntary Active Euthanasia, and Capital Punishment

C. Coons and N. Levin

We argue that the dead donor rule, which states that multiple vital organs should only be taken from dead patients, is justified neither in principle nor in practice. We use a thought experiment and a guiding assumption in the literature about the justification of moral principles to undermine the theoretical justification for the rule. We then offer two real world analogues to this thought experiment, voluntary active euthanasia and capital punishment, and argue that the moral permissibility of terminating any patient through the removal of vital organs cannot turn on whether or not the practice violates the dead donor rule. Next, we consider practical justifications for the dead donor rule. Specifically, we consider whether there are compelling reasons to promulgate the rule even though its corresponding moral principle is not theoretically justified. We argue that there are no such reasons. In fact, we argue that promulgating the rule may actually decrease public trust in organ procurement procedures and medical institutions generally—even in states that do not permit capital punishment or voluntary active euthanasia. Finally, we examine our case against the dead donor rule in the light of common arguments for it. We find that these arguments are often misplaced—they do not support the dead donor rule. Instead, they support the quite different rule that patients should not be killed *for* their vital organs.

Clinics in Perinatology

Volume 36, Number 2
June 2009

Ethics of Fetal Surgery

F. A. Chervenak and L. B. McCullough

This article provides a comprehensive approach to the ethics of clinical investigation of fetal surgery. Investigators should address the initiation and assessment of clinical trials to determine whether they establish a standard of care and use an appropriate informed consent process to recruit and enroll subjects, consider whether selection criteria should include the abortion preferences of the pregnant woman, and consider whether

physicians have an obligation to offer referral to such investigation. This approach is comprehensive because it takes account of the physician's obligations to the fetal patient, the pregnant woman, and future fetal and pregnant patients. The comprehensive approach to the ethics of fetal surgery is applied to the example of in utero surgical management of spina bifida.

Journal of Law, Medicine and Ethics

Volume 35, Number 5
May 2009

Is There A Duty to Share Genetic Information?

S. M. Liao

A number of prominent bioethicists, such as Parker, Lucassen and Knoppers, have called for the adoption of a system in which by default genetic information is shared among family members. This paper suggests that a main reason given in support of this call to share genetic information among family members is the idea that genetic information is essentially familial in nature. On examining this "familial nature of genetics" argument, the paper shows that most genetic information is only shared in a weaker way among family members and does not necessarily lead to the actual manifestation of particular diseases. The upshot is that the idea that genetic information is familial in nature does not provide sufficient ground for moving towards a system in which by default genetic information is shared among family members.

Volume 37, Number 1
Spring 2009

The Vulnerability of the Very Sick

J. Menikoff

When seriously ill patients for whom existing treatments are inadequate are invited to participate in clinical trials that offer a new treatment, should those persons be considered "vulnerable"? And if so, what additional protections should they be accorded? This article attempts to provide some answers.

Journal of Medical Ethics

Volume 37, Number 2
February 2011

Ethical Challenges in Fetal Surgery

A. Smajdor

Fetal surgery has been practised for some decades now. However, it remains a highly complex area, both medically and ethically. This paper shows how the routine use of ultrasound has been a catalyst for fetal surgery, in creating new needs and new incentives for intervention. Some of the needs met by fetal surgery are those of parents and clinicians who experience stress while waiting for the birth of a fetus with known anomalies. The paper suggests that the role of technology and visualisation techniques in creating and meeting such new needs is ethically problematic. It then addresses the idea that fetal surgery should be restricted to interventions that are life-saving for the fetus, arguing that this restriction is unduly paternalistic. Fetal surgery poses challenges for an autonomy-based system of ethics. However, it is risky to circumvent these challenges by restricting the choices open to pregnant women, even when these choices appear excessively altruistic.

Volume 36, Number 10
October 2010

Decapitation and the Definition of Death

F. G. Miller and R. D. Truog

Although established in the law and current practice, the determination of death according to neurological criteria continues to be controversial. Some scholars have advocated return to the traditional circulatory and respiratory criteria for determining death because individuals diagnosed as 'brain dead' display

an extensive range of integrated biological functioning with the aid of mechanical ventilation. Others have attempted to refute this stance by appealing to the analogy between decapitation and brain death. Since a decapitated animal is obviously dead, and 'brain death' represents physiological decapitation, brain dead individuals must be dead. In this article we refute this 'decapitation gambit.' We argue that decapitated animals are not necessarily dead, and that, moreover, the analogy between decapitation and the clinical syndrome of brain death is flawed.

Journal of Medicine and Philosophy

Volume 33, Number 2
April 2008

Four Queries concerning the Metaphysics of Early Human Embryogenesis

A. A. Howsepian

In this essay, I attempt to provide answers to the following four queries concerning the metaphysics of early human embryogenesis. Following its first cellular fission, is it coherent to claim that one and only one of two "blastomeric" twins of a human zygote is identical with that zygote? Following the fusion of two human pre-embryos, is it coherent to claim that one and only one pre-fusion pre-embryo is identical with that postfusion pre-embryo? Does a live human being come into existence only when its brain comes into existence? At implantation, does a pre-embryo become a mere part of its mother? I argue that either if things have quidditative properties or if criterialism is false, then queries and can be answered in the affirmative; that in light of recent developments in theories of human death and in light of a more "functional" theory of brains, query can be answered in the negative; and that plausible mereological principles require a negative answer to query.

Volume 34, Number 1
February 2009

Brain Damage and the Moral Significance of Consciousness

G. Kahane and J. Savulescu

Neuroimaging studies of brain-damaged patients diagnosed as in the vegetative state suggest that the patients might be conscious. This might seem to raise no new ethical questions given that in related disputes both sides agree that evidence for consciousness gives strong reason to preserve life. We question this assumption. We clarify the widely held but obscure principle that consciousness is morally significant. It is hard to apply this principle to difficult cases given that philosophers of mind distinguish between a range of notions of consciousness and that is unclear which of these is assumed by the principle. We suggest that the morally relevant notion is that of phenomenal consciousness and then use our analysis to interpret cases of brain damage. We argue that enjoyment of consciousness might actually give stronger moral reasons not to preserve a patient's life and, indeed, that these might be stronger when patients retain significant cognitive function.

Volume 36, Number 3
July 2011

Confronting Moral Pluralism in Posttraditional Western Societies: Bioethics Critically Reassessed

H. T. Engelhardt

In the face of the moral pluralism that results from the death of God and the abandonment of a God's eye perspective in secular philosophy, bioethics arose in a context that renders it essentially incapable of giving answers to substantive moral questions, such as concerning the permissibility of abortion, human embryonic stem cell research, euthanasia, etc. Indeed, it is only when bioethics understands its own limitations and those of secular moral philosophy in general can it better appreciate those tasks that it can actually usefully perform in both the clinical and academic setting. It is the task of this

paper to understand and reevaluate bioethics by understanding these limits. Academic bioethicists can analyze ideas, concepts, and claims necessary to understanding the moral questions raised in health care, assessing the arguments related to these issues, and provide an understanding of the different moral perspectives on bioethical issues. In the clinical setting, bioethicists can provide legal advice, serve as experts on IRBs, mediating disputes, facilitating decision-making and risk management, and clarifying normative issues. However, understanding this is only possible when one understands the history, genesis, and foundations of bioethics and its inability to provide a resolution to postmodern moral pluralism.

Kennedy Institute of Ethics Journal

Volume 18, Number 2
June 2008

A Proposed Ethical Framework for Vaccine Mandates: Competing Values and the Case of HPV

R.I. Field and A.L. Caplan

Debates over vaccine mandates raise intense emotions, as reflected in the current controversy over whether to mandate the vaccine against human papilloma virus (HPV), the virus that can cause cervical cancer. Public health ethics so far has failed to facilitate meaningful dialogue between the opposing sides. When stripped of its emotional charge, the debate can be framed as a contest between competing ethical values. This framework can be conceptualized graphically as a conflict between autonomy on the one hand, which militates against government intrusion, and beneficence, utilitarianism, justice, and nonmaleficence on the other, which may lend support to intervention. When applied to the HPV vaccine, this framework would support a mandate based on utilitarianism, if certain conditions are met and if herd immunity is a realistic objective.

Neuroethics

Volume 2, Number 1
November 2009

Will Neuroscientific Discoveries about Free Will and Selfhood Change Our Ethical Practices?

C. Kaposy

Over the past few years, a number of authors in the new field of neuroethics have claimed that there is an ethical challenge presented by the likelihood that the findings of neuroscience will undermine many common assumptions about human agency and selfhood. These authors claim that neuroscience shows that human agents have no free will, and that our sense of being a "self" is an illusory construction of our brains. Furthermore, some commentators predict that our ethical practices of assigning moral blame, or of recognizing others as persons rather than as objects, will change as a result of neuroscientific discoveries that debunk free will and the concept of the self. I contest suggestions that neuroscience's conclusions about the illusory nature of free will and the self will cause significant change in our practices. I argue that we have self-interested reasons to resist allowing neuroscience to determine core beliefs about ourselves.

Philosophical Studies

Volume 146, Number 2
November 2009

The Loop Case and Kamm's Doctrine of Triple Effect

S.M. Liao

Judith Jarvis Thomson's Loop Case is particularly significant in normative ethics because it calls into question the validity of the intuitively plausible Doctrine of Double Effect, according to which there is a significant difference between harm that is intended and harm that is merely foreseen and not intended. Recently, Frances Kamm

has argued that what she calls the Doctrine of Triple Effect (DTE), which draws a distinction between acting because-of and acting in-order-to, can account for our judgment about the Loop Case. In this paper, I first argue that even if the distinction drawn by DTE can be sustained, it does not seem to apply to the Loop Case. Moreover, I question whether this distinction has any normative significance. The upshot is that I am skeptical that DTE can explain our judgment about the Loop Case.

Prenatal Diagnosis

Volume 31, Number 7
July 2011

Fetal Therapy: Practical Ethical Considerations

Y. Ville

Progress in prenatal diagnosis can lead to the diagnosis of severe fetal abnormalities for which natural history anticipates a fatal outcome or the development of severe disability despite optimal postnatal care. Intrauterine therapy can be offered in these selected cases. Prenatal diagnosis is the only field of medicine in which termination is an option in the management of severe diseases. Fetal therapy has therefore developed as an alternative to fatalist expectant prenatal management as well as to termination of pregnancy (TOP). There are few standards of fetal care that have gone beyond the stage of equipoise and even fewer have been established based on appropriate studies comparing pre- and postnatal care. Several ethical questions are being raised as fetal surgery develops, including basic Hippocratic principles of patients' autonomy and doctors' duty of competence moving the boundaries between experimental surgery, therapeutic innovation and standard care. In addition, the technical success of a fetal intervention can only rarely fully predict the postnatal outcome. Managing uncertainty regarding long-term morbidity and the possibility for fetal therapy to change the risk of perinatal death into that of severe handicap remains a critical factor affecting women's choice for TOP as an alternative to fetal therapy.

Utilitas

Volume 23, Number 2
May 2011

Twinning and Fusion as Arguments against the Moral Standing of the Early Human Embryo

M. Ramsay

Some philosophers argue that, because it is subject to twinning and fusion, the early human embryo cannot hold strong moral standing. Supposedly, the fact that an early human embryo can twin or fuse with another embryo entails that it is not a distinct individual, thus precluding it from holding any level of moral standing. I argue that appeals to twinning and fusion fail to show that the early human embryo is not a distinct individual and that these appeals do not provide us with plausible reasons for denying the strong moral standing of the early human embryo. I recognize one possible exception to this general assessment, a particular version of the appeal to fusion. Embryo fusion that results in tetragametic chimerism provides some reason for doubting the early human embryo's moral standing. But twinning and fusion are otherwise irrelevant in this context.