

## Moral considerations and in-utero babies

As life-saving technology increases, we must ensure that moral decision-making keeps up. Consider a baby in-utero, who has a large tumour likely to make normal birth difficult and dangerous, for mother and child. Attempts to deliver the baby may result in significant lack of oxygen, with brain damage in the baby, and heavy bleeding from the mother. It would be ideal to have a team perform caesarean section and then partially deliver the baby's head and neck. This offers the best chance for insertion of a breathing tube, while keeping the baby's oxygen levels high and preventing heavy bleeding from the mother.

What if, however, the mum says no to any sort of active intervention, and wants a normal birth, leaving the ultimate outcome to the will of God? This could very well have far-reaching implications for the baby, the mum, their family, and also for the doctors and nurses attending the birth.

One of the defining features of our current era is its value pluralism. That is, people have a diverse range of beliefs and values which are important to them. Widespread immigration and global communication, means that diverse values are widely spread. The traditional ethical frameworks may no longer be appropriate. *Deontology* argues that some things must not be done (torturing a terrorist is never allowable). *Teleology* argues that what is allowed depends upon the consequences (torturing a terrorist is OK if a great number of innocents will benefit). *Virtue ethics* depends upon the character of the actor, and in medicine seeks to maximise the good, in the situation. *Theism* is aware of an hereafter. Other guiding principles may also be inadequate in modern-day medical dilemmas.

An active moral decision-making *process* is better. That process is a dialogue or discussion or discourse - which is non-coercive (no manipulative pressure is applied to individuals in the discussion), and which aims to reach a consensus amongst those affected. It aims to explore the values the family holds to be important, as well as the values which the doctors and nurses prioritize, and by so-doing, maximize the good of all involved.

In order to achieve this, the case conferences must encourage ideal speech conditions for a dialogue. The goal is mutual understanding of the reality of the situation, as well as the values held by family and staff. This not simply a majority vote, or a discussion orchestrated by those with better skills in persuading people to their way of thinking. It is a process which can and must be founded upon principles which foster a genuine unforced consensus after meaningful dialogue. Achieving truth in the dialogue requires an awareness of different ways of knowing – 1)data collection and explanation, 2)understanding meanings and values (without this, the good cannot be maximised), and 3)self-reflection. Despite the likely different socio-cultural and moral backgrounds of the participants, good clinicians and good parents dialogue about the morally conflicted situation they are in.

Understanding the process of *consensual dialogical consensus* offers significant advantages to the parents. They can be reassured that they don't have to make the decision alone - all of us having

the dialogue make the decision jointly. Thus the decision has what is known as *normative force* – it has *oughtness* or *shouldness* associated with it. The family is less likely to have doubts about whether the best decision was made.

No doubt there are difficulties. However there is a need for a moral philosophical framework which recognises the perspective of others, and which allows that principles of conduct towards others can be determined, no matter how one's own ethical values, conceptions of the good, or life-choices differ.

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## Publication

[Moral considerations in non-EXIT airway management.](#)

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