Bioethics for clinicians: 12. Ethical dilemmas that arise in the care of pregnant women: rethinking "maternal–fetal conflicts"

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Abstract

WHEN A PREGNANT WOMAN MAKES A DECISION or acts in a manner that may be detrimental to the health and well-being of her fetus, her physician may be faced with an ethical dilemma. Is the physician's primary duty to respect the woman's autonomy, or to promote behaviour that may be in the best interest of the fetus? The controversial concept of "fetal rights" or the "fetus as a patient" contributes to the notion that the pregnant woman and her fetus are potential adversaries. However, Canadian law has upheld women's right to life, liberty and security of the person and has not recognized fetal rights. If a woman is competent and refuses medical advice, her decision must be respected even if the physician believes that her fetus will suffer as a result. Coercion of the woman is not permissible no matter what appears to be in the best interest of the fetus.

Résumé

LORSQU'UNE FEMME ENCEINTE PREND UNE DÉCISION ou agit d'une façon qui peuvent nuire à la santé et au mieux-être de son foetus, son médecin peut se retrouver aux prises avec un dilemme éthique. Le médecin doit-il d'abord respecter l'autonomie de la femme ou promouvoir un comportement qui serait dans le meilleur intérêt du foetus? Le principe controversé des «droits du foetus» ou du «foetus comme patient» contribue au concept selon lequel la femme enceinte et son foetus peuvent devenir des adversaires. La loi canadienne a toutefois maintenu le droit à la vie, à la liberté et à la sécurité de la personne pour les femmes et n'a pas reconnu les droits du foetus. Si une femme capable refuse de suivre un conseil médical, il faut respecter sa décision, même si le médecin est d'avis que le foetus en souffrira. La coercition de la femme n'est pas permise, peu importe ce qui semble être dans le meilleur intérêt du foetus.

Ms. A is 19 years old and is 25 weeks pregnant. During a prenatal office visit she reveals that her partner is bisexual and may have been exposed to HIV. Her physician advises her to have an HIV test, explaining that if she is seropositive treatment is available that may slow the disease process. Moreover, treatment may reduce the risk of HIV transmission to the fetus. In spite of this information, Ms. A refuses HIV testing.

Ms. B is 24 years old and has been in labour for 18 hours. The cervical dilatation has not progressed past 3 cm. The fetal heart rate tracing has been worrisome but is now seriously abnormal, showing a profound bradycardia of 65 beats per minute. This bradycardia does not resolve with conservative measures. Repeat pelvic examination reveals no prolapsed cord and confirms a vertex presentation at 3 cm dilatation. The obstetrician explains to Ms. B that cesarean section will be necessary in view of the fetal distress. Ms. B absolutely refuses, saying "No surgery."

What are maternal–fetal dilemmas?

When a physician believes that he or she has a moral obligation to pursue 2 conflicting courses of action, he or she faces a moral dilemma.[1] In the care of preg-

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Éducation

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nant women, moral dilemmas can arise when the physician believes that her obligation to respect a patient's decision conflicts with her obligation to protect the fetus from harm. This conflict can arise in at least 3 separate realms, that is, with respect to the woman's personal health care choices, lifestyle and behaviours, and occupational situation. In practice and in the literature, these unfortunate situations are often described as "maternal–fetal conflicts."[2–4]

The use of this term is problematic for several reasons. First, it situates the conflict between the pregnant woman and the fetus, whereas the conflict is really between the pregnant woman and others who believe that they know best how to protect the fetus.[5] These others may be seen to act from a sense of professional duty or as agents of the state (on behalf of society at large) and may include third parties such as child welfare agencies, physicians and other health care providers.[3,4,6] Second, the term perpetuates the underlying but unfounded assumption that the problem involves the opposition of maternal rights against fetal rights. At most, there is a conflict between the woman's autonomy and the best interest of the fetus. Some caregivers are committed to respecting the pregnant woman's wishes; others deem that state intervention to protect the fetus is both necessary and appropriate in some circumstances. Finally, the term "maternal–fetal conflict" is factually incorrect. The term "maternal" suggests the existence of parental obligation toward the fetus, whereas the woman is *yet to become* a mother to the fetus she is carrying. This is a significant distinction. Although the term "maternal–fetal conflicts" has gained currency, we advocate the use of the more descriptive phrase, "ethical dilemmas that arise in the care of pregnant women."

Why are ethical dilemmas that arise in the care of pregnant women important?

Ethics

The principle of reproductive freedom stipulates that people have the right to make their own reproductive choices and that the state has an obligation to foster conditions under which this can occur.[7] For some, this principle is morally objectionable because it grants women the right to make decisions concerning the termination of unwanted pregnancies. In their view, whatever rights the pregnant woman may or may not have do not override the fetus' right to life. The problem with this position is that typically it rests on the highly contested premise that the fetus, like the pregnant woman, is a person — someone whose interests and rights must be respected.

Others do not reject the principle of reproductive freedom but at the same time advocate what they believe to be legitimate restrictions on this principle as it applies to women. They maintain that although the fetus may not have the rights of a person, once the woman has decided "of her own free will" to continue the pregnancy she has obligations to the fetus. Moreover, the state may intervene to limit or preclude actions that would irreversibly harm the fetus.[8,9] Again, this position is problematic. It suggests an opposition between the interests of the woman and those of the fetus, and overlooks the important fact that these interests are inextricably linked. The few women who do risk harming their fetuses typically do not actively seek to cause such harm.

All things being equal, women who bring their pregnancy to term do not want damaged babies. But alas, sometimes a woman's choices are made in ignorance, or are informed by deeply held religious or personal beliefs that preclude certain decisions, or result from strong social and psychological pressures. Any one of these factors can prevent a woman from acting in the best interest of her fetus. Consider, for example, a woman who fears physical and psychological abuse or abandonment by her partner and therefore refuses voluntary HIV testing that might indicate the need for immediate drug therapy to prevent vertical transmission. Were her circumstances different, she would prefer not to have her child born to possibly suffer and die from HIV infection.[10] It should also be noted that continuing a pregnancy does not always involve a deliberate, active choice on the part of the woman. Similarly, many behaviours that may ultimately harm a fetus cannot properly be described as choices, as in the case of addictions.

Recognizing such limitations, some may still argue that state intervention — including forced screening, forced incarceration to prevent continued substance abuse, and forced obstetrical interventions — is morally justified. However, when the issue is considered in its broader social and political context it becomes clear that such interventions are indefensible. First, such coercion is far in excess of any nonvoluntary intervention that would be tolerated to save nonfetal lives. For example, parents are not coerced to become organ donors even when a failure to do so would likely result in the death of their child. We may consider a parent's refusal to make such a donation to be morally reprehensible, but it is beyond the realm of state authority. To coerce a pregnant woman to accept efforts to promote fetal well-being is an unacceptable infringement of her personal autonomy.[11,12]

Second, the harm to women that such coercion represents often occurs without any countervailing benefit to the fetus. For example, there are reports of healthy infants delivered after the woman refused consent for cesarean section that was deemed necessary.[11] Third, state intervention is likely to discourage women whose fetuses may be most at risk from seeking appropriate care.[11,12] It

is also likely to undermine the trust between pregnant women and their health care providers that is necessary to foster the education that would promote the birth of healthier babies.

Finally, state intervention to promote fetal well-being is hypocritical given the inconsistency between aggressive efforts made to rescue a few fetuses from a few women in unfortunate situations and the widespread tolerance for unacceptable and sometimes dangerous living conditions in which many children find themselves.

Law

Canadian law addresses 2 issues relevant to this discussion: it confirms the competent woman's right to refuse treatment and the absence of fetal rights. First, informed consent is a legal necessity in medical practice.[13] Physicians who treat a competent patient without his or her consent put themselves at risk of both criminal and civil liability.[14,15] As well, coercive treatment of a woman by the state contravenes the Canadian Charter of Rights and Freedoms, which recognizes that women and men have equal rights to life, liberty and security of the person.[16]

Second, in common law the fetus does not have legal rights until it is born alive and with complete delivery from the body of the pregnant woman.[17–19] For this reason child protection legislation (which, under certain circumstances, authorizes state intervention) does not apply to the fetus.[20]

A recent decision of the Manitoba Court of Appeal confirms this position.[21] Although the decision of the lower court suggested that there was legal authority to order a pregnant woman to undergo, without consent, counselling and hospital admission to manage a drug addiction, the Court of Appeal confirmed that there was no legal basis on which to do so. This decision confirmed that the fetus is not protected before birth under Canadian law and that the courts have no legal grounds on which to order a competent pregnant woman to undergo a medical intervention that she does not want. An appeal of this case will be heard by the Supreme Court of Canada.

Policy

The CMA Code of Ethics stipulates that a physician "must respect the right of a competent patient to accept or reject any medical care recommended."[22] Consistent with this position is the recommendation of the Royal College of Physicians and Surgeons of Canada that when a physician's view of the best interest of the fetus conflicts with the view of the pregnant woman, the role of the physician is to provide counselling and persuasion, but not coercion.[23]

This view is discussed more fully in the Final Report of the Royal Commission on New Reproductive Technologies,[24] which recommended that:

- medical treatment never be imposed upon a pregnant woman against her wishes,
- criminal law, or any other law, never be used to confine or imprison a pregnant woman in the interest of her fetus,
- the conduct of a pregnant woman in relation to her fetus not be criminalized,
- child welfare or other legislation never be used to control a woman's behaviour during pregnancy, and
- civil liability never be imposed upon a woman for harm done to her fetus during pregnancy.

Empirical studies

One of the justifications for state intervention in pregnancy is the belief that it benefits the fetus. However, reports of good fetal outcomes despite a woman's refusal of cesarean section call this assumption into question.[11,25,26] Unfortunately, there is no standardized system for documenting and assessing cases in which a pregnant woman refuses medical advice.

A review of the few cases that have reached the courts in Canada shows unequivocally that state intervention is disproportionately oppressive of poor women, aboriginal women and women who are members of other racial and ethnic minorities.[27] This finding is cause for concern.

Moreover, the almost exclusive focus on the impact of pregnant women's behaviours and choices on the health and well-being of the fetus reflects an unacceptable gender bias. There is ample evidence to show that paternal drug and alcohol abuse, excessive caffeine and nicotine use, spousal abuse and certain paternal occupations are also potentially hazardous to the fetus.[28–30]

Finally, when attention is directed only toward the pregnant woman's behaviours and choices, the fact that "malnutrition, violence, chaotic lives, serious maternal health problems and lack of medical care"[31] have a significant impact on the health and well-being of the fetus is often overlooked.

How should I approach ethical dilemmas that arise in the care of pregnant women?

Although Canadian law does not recognize fetal rights, fetal interests are taken into consideration by physicians and their pregnant patients. In fact, with the development of detailed ultrasound imaging, excellent perinatal technology and the ability to improve outcomes for very small infants, it is hard for many physicians not to envision the fetus as a patient.[2,32] Thus, some physicians see themselves as having responsibility for 2 "patients" in 1 body. It is extraordinarily difficult for a physician to stand by while a

fetus dies or becomes irreparably harmed when an intervention might prevent this result. Nonetheless, it is still inappropriate either to coerce a patient to undergo an intervention or to abandon her.

Difficult as it may be, the physician must respect the competent woman's right to make decisions for herself and her fetus. Moreover, care must be taken not to question the competence of the woman merely because she does not concur with one's recommendations. The most common reason for rejecting medical advice is not incompetence but fear of the unknown. Other possible reasons are denial, past experience, a bias toward the present and near future, and a lack of trust in the medical profession.[33]

Communication, understanding and respect for women are essential in the management of these difficult situations. However, no matter how skilled a communicator the physician might be, a woman may for reasons of her own not alter her decision or behaviour. The physician's communication skills may be significantly tested in such cases (especially when a decision is needed urgently), and it may be difficult to develop the trust that is integral to the physician–patient relationship.

As in other challenging medical situations, consultation with a colleague can be extremely helpful.

The cases

Because the treatment of HIV-seropositive pregnant women is believed to benefit the fetus, there is ongoing debate about mandatory HIV testing for pregnant women.[34] However, to respect a pregnant woman's autonomy this intervention may not occur without her explicit consent. Issues of possible prejudice or bias with regard to employment, insurance, housing and so on may factor significantly in decisions about HIV testing. From a practical perspective, it is worth emphasizing that testing alone is not an effective intervention that benefits the fetus. If a woman is found to be HIV seropositive, she has the right to refuse treatment even if such treatment is potentially beneficial to the fetus. Therefore, despite the increased risk that Ms. A may be HIV seropositive, the physician must respect her refusal of HIV testing.

Further discussion clarifies that Ms. B is terrified of general anesthesia because her mother died from anesthesia complications. Moreover, Ms. B has a strong distrust of physicians and believes that too many cesarean sections are done. When it is explained that the cesarean can be done with spinal anesthesia, and in view of the risks of the ongoing bradycardia, Ms. B agrees to the surgery. However, if the patient had continued to refuse the surgery, the physician would have been obliged to respect her decision despite the serious risks to the fetus.

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