Session 13. Maternal-Fetal Conflict

Susan F. Townsend, MD, FAAP

Overview

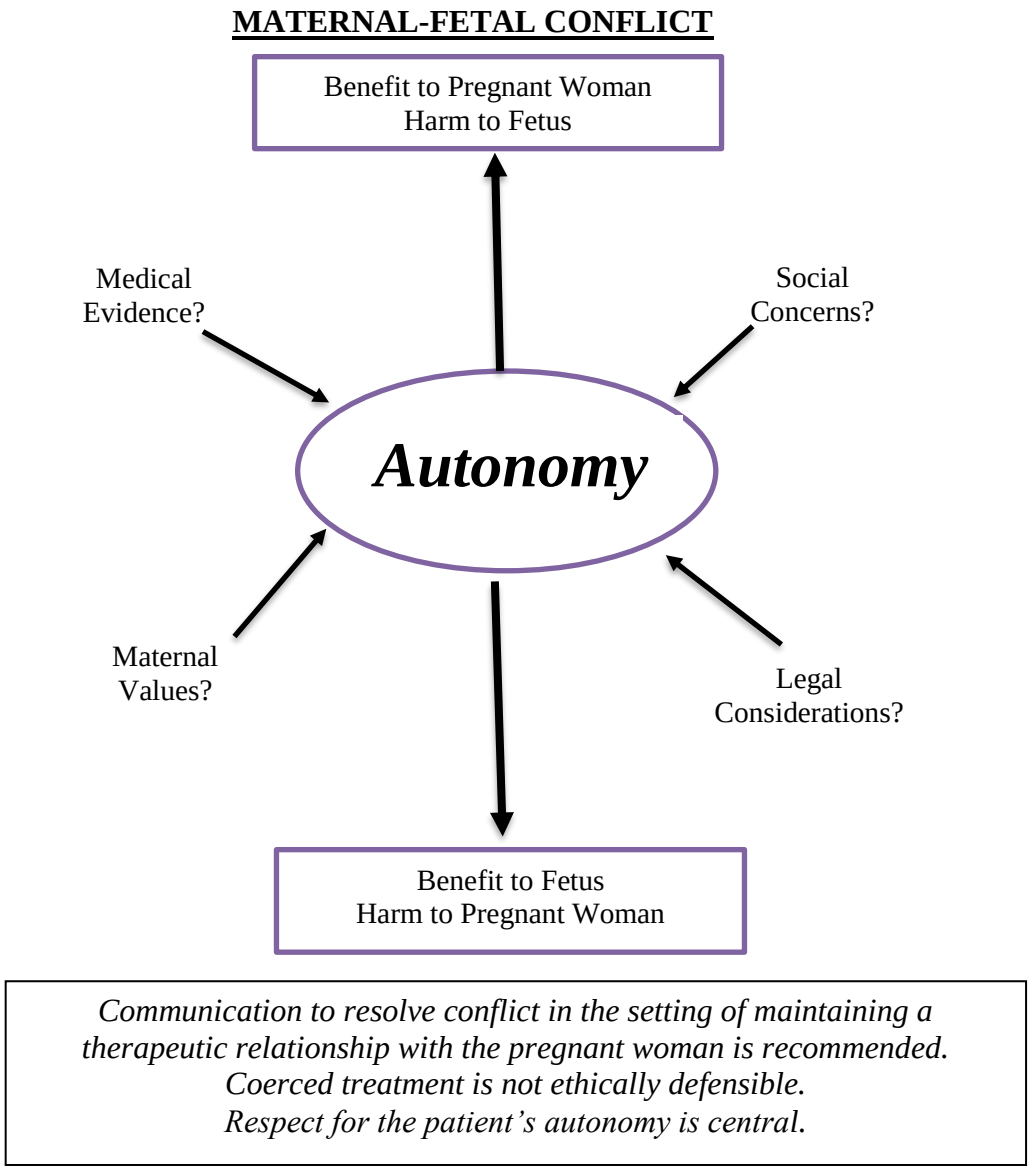
Pregnancy is unique in medical ethics because of the absolute requirement to access the fetus only through intervention on or treatment to the pregnant woman. Increasingly, as medical advances offer the promise of therapy to the fetus, fetal interests have been considered separately from maternal interests by clinicians, policy makers, and the bioethics community. Despite this distinction in interests, maternal and fetal interests usually are aligned, and care of the fetus is intertwined with and dependent on care of the pregnant woman.

When conflict arises between maternal and fetal interests (eg, maternal refusal of treatment that may benefit the fetus), then a variety of ethical frameworks can support clinical decision making, in addition to principle-based approaches. Helpful tools include feminist theory, case-based analysis, and the ethics of care, along with principles of autonomy, beneficence/nonmaleficence, and justice. The concern for maternal-fetal conflict is often emotionally laden and can benefit from a thoughtful analysis that includes a variety of perspectives.

Ultimately, moral theory instructs the health care provider to accept the pregnant woman's informed consent or refusal of treatment, according respect to her autonomy and bodily integrity, as well as her values regarding pregnancy outcome. In cases in which a woman's decision may harm her fetus, coercion to force treatment is never ethically justified. In extraordinary cases, legal interventions have been attempted. Using courts to enforce treatment compliance by pregnant women has been unsuccessful, or has activated processes that are hasty and incomplete, with some court rulings overturned on appeal. Evidence shows that continuing a trusting, compassionate, professional relationship with the pregnant woman generally results in greater improvement of maternal and child health. Exploring of provider values may detect subtle, gender-based biases in the clinicians' approaches to conflict resolution, and support collaborative decision-making for the pregnant woman and her healthcare team, with respect for maternal autonomy the core ethical principle.

This module will explore considerations of the pregnant woman's right to refuse recommended treatment or testing, if the fetus may be harmed by her decision. Participants will learn the ethical underpinnings of approaches to maternal refusal of treatment, discuss whether there are limits to a pregnant woman's autonomy, and become

familiar with strategies for conflict resolution to optimize health outcomes for both the pregnant woman and her fetus.



Communication to resolve conflict in the setting of maintaining a therapeutic relationship with the pregnant woman is recommended.
Coerced treatment is not ethically defensible.
Respect for the patient's autonomy is central.

Instructor's Guide

- Case Summary
- Alternative Cases
- Learning Objectives
- Suggested Reading for Instructors
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- Conclusions and Suggestions

Case Summary

Jesse is a 24-year-old primigravida woman (G1 P0) who presents at term to the hospital in active labor having received care at home with a local midwife for a planned home birth. Her midwife sent her to the hospital because the fetus seemed quite large and she was concerned for dystocia. Jesse is told that a cesarean section is the best route of delivery for the fetus' well-being. She declines the operation and requests a natural childbirth. The fetus begins to have heart rate abnormalities, suggesting a nonreassuring status. Jesse continues to decline the recommended cesarean section.

- Can the pregnant woman refuse the recommended treatment (a cesarean section)?
- If so, can you perform the treatment (a cesarean section) without her consent?
- Are there limits to her ability to refuse treatment (autonomy)?
- Would your considerations be different if the fetus was extremely premature versus full term or had anomalies? If so, why?
- How should you ethically proceed to optimize both the pregnant woman's and the future child's health outcomes?

Alternative Cases

1. Lila presents at full term in labor, with no previous prenatal care. She reports using heroin just prior to admission, and also smokes marijuana and tobacco daily. She is asked to consent to urine toxicology screening and refuses. When the membranes rupture, there is some meconium staining noted in the amniotic fluid. After several hours of labor, she delivers a 2.5-kg male infant who is vigorous at birth and goes to the well-baby nursery. The pediatrician asks for Lila's permission to perform a urine toxicology and meconium drug screen on the infant, per hospital policy. Lila refuses to consent to these screens. She plans to breastfeed her son. Consider the questions above in terms of refusing testing that would lead to treatment.

Learning Objectives

1. Understand the central tenet of respect for the autonomy of the pregnant woman in the context of medical decision making.
2. Recognize that maternal and fetal interests are intertwined, and the fetus should not be considered separate from the pregnant woman as a patient.
3. Be aware of the evidence and uncertainty around some recommended treatments and the potential for gender and social bias inherent to attempts for legal remedies that favor the interests of the fetus over those of the pregnant woman.
4. Identify strategies for conflict resolution that maintain a therapeutic doctor-patient relationship and have been shown to improve pregnancy outcomes.

Suggested Reading for Instructor

American College of Obstetricians and Gynecologists. Refusal of medically recommended treatment during pregnancy. Committee Opinion No. 664. *Obstet Gynecol*. 2016;127(6):e175-e182 http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Ethics/Refusal-of-Medically-Recommended-Treatment-During-Pregnancy (accessed August 1, 2016)

American College of Obstetricians and Gynecologists. Alcohol abuse and other substance use disorders: ethical issues in obstetric and gynecologic practice. Committee Opinion No. 633. *Obstet Gynecol*. 2015;125(6):1529-1537

Hollander M, van Dillen J, Lagro-Janssen T, Vandenbusschen F. Women refusing standard obstetric care: maternal-fetal conflict or doctor-patient conflict? *J Preg Child Health*. 2016;3(2):251-255

Further Reading

American College of Obstetricians and Gynecologists, Committee on Ethics; American Academy of Pediatrics, Committee on Bioethics. Maternal-fetal intervention and fetal care centers. *Pediatrics*. 2011;128(2):e473-478

Brown SD, Truog RD, Johnson JA, Ecker JL. Do differences in the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists positions on the ethics of maternal-fetal interventions reflect subtly divergent professional sensitivities to pregnant women and fetuses? *Pediatrics*. 2006;117(4):1382-1387

Kremer ME, Arora KS. Clinical, ethical, and legal considerations in pregnant women with opioid abuse. *Obstet Gynecol*. 2015;126(3):474-478

Harris LH. Rethinking maternal-fetal conflict: gender and equality in perinatal ethics. *Obstet Gynecol*. 2000;96(5 Pt 1):786-791

Tessmer-Tuck JA, Poku JK, Burkle CM. When courts intervene: public health, legal and ethical issues surrounding HIV, pregnant women, and newborn infants. *Am J Obstet Gynecol*. 2014;211(5):461-469

Case Discussion

Who is the patient here: the pregnant woman, the fetus, or both?

Increasing use of technology to evaluate the fetus during pregnancy has led physicians and society to consider the fetus as a patient separate from the pregnant woman. This has led to the view of the fetus as having separate interests to be addressed by the medical team providing care. Language around obstetrical decision making has reinforced the

separate consideration of the fetus from the pregnant woman (such as “fetal distress” or “fetal interests”). Nonetheless, access to the fetus for treatment must occur through the pregnant woman’s body, a unique situation. Consider other situations where medical intervention to benefit one patient (eg, a child with end-stage renal failure needing a transplant) involves risk to another patient (eg, organ donation) when the 2 patients are not “intertwined.” Would you consider both individuals to be your “patient” if you were the transplant surgeon? As a pediatrician, would you hope/expect or mandate a parent to donate a kidney to a child under such circumstances?

Are there limits to when a pregnant woman can refuse medically recommended treatment?

The American College of Obstetricians and Gynecologists (ACOG) Committee on Ethics states in Committee Opinion No. 664 that “Pregnancy is not an exception to the principle that a decisionally capable patient has the right to refuse treatment, even treatment needed to maintain life.” Therefore, respect for autonomy compels us to honor the patient’s decision. If a pregnant woman lacks decisional capacity (eg, is in a coma), then a surrogate should be consulted, ideally making decisions based on her previously expressed wishes.

What is an ethical framework to address the complexities of refusing treatment during pregnancy?

It is important to recognize a pregnant woman’s freedom to make decisions and not be coerced into treatment. Coercion is never ethically defensible, and the pregnant woman has a fundamental right to control over her body. According to ACOG, the provider has an ethical obligation to respect the patient’s (pregnant woman’s) informed decisions, even if there is a beneficence-based motivation toward the fetus of a woman who presents for care. That said, it is important to recognize that most pregnant women do want to help their fetus, and the maternal fetal relationship is not typically adversarial. Although coercion is unacceptable, discussion and perhaps persuasion with compassion and clarity about goals and fears, to ensure the mother appropriately understands the risks and benefits for herself and her fetus with and without the recommended treatment, best serves her autonomy and the fetal interests.

Should we use the legal system to obtain court-ordered interventions?

In many situations of obstetric conflict, such as refusal of a cesarean section, the body of evidence supporting the recommended intervention may not be comprehensive or as conclusive as initially presented. The medical evidence supporting any recommendation for route of delivery is often incomplete. In cases in which courts have intervened to order cesarean section, for example, the fetus in a third of cases has been delivered vaginally and unharmed. When evidence in support of the treatment recommendation is weak, uncertain, or not available and outcomes vary, there is poor ability to predict individual outcomes. Therefore, it is important to know the objective evidence. Legal or court-ordered interventions against a pregnant woman with decisional capacity are controversial at best and widely demonstrate socioeconomic and racial disparities as well. In addition, in cases in which chronic medical conditions during pregnancy, such us substance use disorders, are criminalized, pregnant women may not seek care, resulting in worse pregnancy outcomes. Coerced interventions including using courts to order treatment should be discouraged and avoided.

Is there an evidence-based approach to conflict resolution when pregnant women refuse medically recommended treatment?
Maintaining a therapeutic relationship with your patient is generally recommended to defuse tension and support additional informed medical decision making. Demonstrating respect for patient autonomy and bodily integrity, conveying empathy, and seeking to understand the patient's values and perspective can help address concerns and potentially allow progress towards conflict resolution. In situations such as drug abuse or HIV therapy refusal, it is important to appreciate that medical therapy offered is important for the woman's health, and not just based on fetal rights. Open discussion and perhaps persuasion with the woman about this might be of benefit. At the same time, many women do want to do what is best for their fetus, and perhaps this could be useful to address.

Can the pregnant woman refuse the recommended treatment, particularly if harm is expected to come to the fetus?
Yes. However, projected harm should neither be exaggerated nor dismissed. Continued conversation with the pregnant woman as labor progresses may lead to changes in her decision. Preserving the physician-patient relationship in a compassionate, professional manner will allow ongoing reevaluation of the decision, depending on whether the fetal status improves or worsens and the mother is able to deliver vaginally or not.

Does the gestational age of the fetus have a bearing on decision making?
Fetal interests and medical analysis of the benefits and harms of delivery will vary with gestational age. However, there may be fewer data and even more uncertainty regarding outcome at extremely early gestations, and this should be acknowledged.

Are there additional considerations related to counseling around HIV testing and treatment than in other situations of maternal fetal conflict?
Communitarian ethics (placing a value on the health of the community that can override autonomy) informs much of the approach to routine prenatal screening with attention to public health concerns such as limiting the spread of communicable diseases (eg, syphilis). Routine prenatal screening for HIV is recommended by the Centers for Disease Control and Prevention; however, social stigma and the history of HIV, as well as evolving concepts of maternal autonomy, have resulted in varying state laws about prenatal screening for HIV, often described as "opt-in" or "opt-out" approaches.
Discussions should focus on why HIV testing is considered different from, for example, syphilis testing of pregnant women and newborn infants. Again, legal remedies and coercive strategies may lead to families to avoid other medically recommended treatments and worsen long-term outcomes.

Does substance use testing of pregnant women improve neonatal outcomes?
In general, narcotic use in pregnancy affects the fetus and places the newborn infant at risk for neonatal abstinence syndrome (NAS). The risk for NAS appears to be unrelated to dose/exposure. Narcotic use in pregnancy is an increasing national concern, and maternal use is an opportunity to provide treatment to pregnant women. Therefore, universal screening in pregnancy is recommended. Treating NAS in the newborn infant is based on observing for symptoms of central nervous system and sympathetic nervous system

activation. Arguably, the maternal history alone can support monitoring the newborn for NAS symptoms, and treatment is based on symptom detection. At present, long-term effects of in utero narcotic exposure (alone) on children are minimal or unknown. Forced testing may have significant social, criminal, or other legal consequences for women. It is important for providers to disclose any testing to a pregnant woman and to be aware of hospital and community policies and laws related to substance use.

Conclusions and Suggestions

Remember that the interests of the pregnant woman are generally aligned with those of her fetus. When they are not, there is an ethical motivation to consider fetal interests, but an ethical *obligation* to respect the autonomy of the pregnant woman in refusing medically recommended treatments or testing.

Concerns about potential harm to the fetus related to maternal decisions must be evaluated in the context of the best medical evidence as well as each woman's broad social network and her cultural beliefs and values. Medical evidence should be presented objectively, detailing what is known and what is uncertain. Potential options and outcomes may vary with fetal gestation.

Gender bias and discrimination toward women should be avoided, and the circumstance of pregnancy should not be used as a reason to infringe on or limit a competent woman's rights.

Evidence shows that providing prenatal care and treatment in a supportive rather than coercive way is the most effective way to promote both maternal and child health.

Hospital guidelines can be developed to support a framework of shared decision making in the situation of maternal-fetal conflict and provide guidance for compassionate conflict resolution. At times, an ethics consult may be helpful to mediate conflict resolution. Intervention by the courts is rarely appropriate or indicated and should be avoided.

This instructor's guide is part of a collection edited by Douglas S. Diekema, MD, MPH, FAAP; Steven R. Leuthner, MD, MA FAAP; Felipe E. Vizcarrondo, MD, MA, FAAP on behalf of the American Academy of Pediatrics Committee on Bioethics and Section on Bioethics.