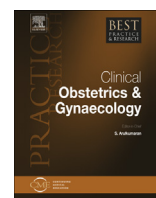




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Bioethical considerations



Ophra Leyser-Whalen, PhD, Assistant Professor^{a,*},
 Erma Lawson, RN, PhD, Assistant Professor^{b,1},
 Arlene Macdonald, PhD, Assistant Professor^{c,2},
 Jeff R. Temple, PhD, Associate Professor^{d,3},
 John Y. Phelps, MD, JD, Clinical Associate Professor^d

^a Department of Sociology & Anthropology, University of Texas at El Paso, 500 University Ave., El Paso, TX 79968, USA

^b University of North Texas, 1155 Union Circle #311157, Chilton Hall, Suite 390, Denton, TX 76203, USA

^c Institute for the Medical Humanities, University of Texas Medical Branch, 301 University Blvd, Galveston, TX 77555-1311, USA

^d Department of Ob/Gyn, UTMB Health, 301 University Blvd, Galveston, TX 77555-0587, USA

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The clinical literature notes that pregnancy has become an expected benefit of solid organ transplant. Establishing “best practices” in the management of this particular transplant population requires careful consideration of the ethical dimensions, broadly speaking, of posttransplant pregnancies and these women's lived experiences. In this article, we present the current clinical and social science posttransplant pregnancy research. We specifically address the psychosocial and ethical issues surrounding preconception counseling and posttransplant health quality of life and mothering and suggest areas for future research.

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Introduction

The clinical literature notes that pregnancy has become an expected benefit of solid organ transplant [1–3]. This expectation is inculcated in an ever-growing number of women, given the growing

* Corresponding author. Tel.: +1 (915) 747 6587; Fax: +1 (915) 747 5505.

E-mail addresses: oleyserwhalen@utep.edu (O. Leyser-Whalen), Elawson@unt.edu (E. Lawson), almacdon@utmb.edu (A. Macdonald), jtemple@utmb.edu (J.R. Temple), jyphelps@utmb.edu (J.Y. Phelps).

¹ Tel.: +1 940 565 2296; Fax: +1 940 369 7035.

² Tel.: +1 409 772 9325; Fax: +1 409 772 9352.

³ Tel.: +1 409 747 8560.

number of recipients of reproductive age and the increasing numbers of recipients who will eventually reach reproductive age [4]. The expectation that transplantation can, or perhaps ought to, generate reproductive opportunities is inherent in the pursuit of uterine transplants. Yet the very idea that pregnancy could be considered an “expected” benefit of transplant is itself novel and a reversal of the earlier perspective that posttransplant pregnancies posed too many threats to the health of the mother, the child, and the graft organ [5,6].

However, several decades of clinical experience with posttransplant pregnancy have largely overturned the previous stance.^e These data come from smaller clinical studies from several countries as well as from large registries such as US pregnancy-related data in the National Transplant Pregnancy Registry (NTPR) and the UK Transplant Pregnancy Registry. For example, recent clinical literature often refers to the “successful” outcomes of posttransplant pregnancies in fertile women with various end-stage organ diseases [7–9]. Based on data from the NTPR, approximately 70% of all posttransplant pregnancies result in successful live birth, although lung recipients appear to have the greatest risks of poorer pregnancy outcomes [10]. These data come mostly from kidney transplants, followed by liver and heart. Not only do most of these pregnancies not significantly alter graft function [10–12] but also by the measure of live births, these pregnancies are comparable to population-wide statistics [7,9] and qualify as successful.

Given the personal and social centrality that reproduction plays in women's lives, the older practice of actively discouraging female transplant patients from pursuing pregnancy on the basis of inadequate or unexamined evidence was clearly ethically fraught, although medically sound – given that no animal experiment could be preliminarily undertaken, prudence was mandatory. The transplant profession's new openness to, and clinical support for, a wider range of reproductive choices for female recipients is laudable. However, establishing “best practice” in the management of this particular transplant population requires careful consideration of the ethical dimensions of posttransplant pregnancies. It also requires careful consideration of the psychosocial dimensions of posttransplant pregnancies. Increasingly, bioethicists are acknowledging sociological theories, epistemologies, and methodologies as vital to appreciating the complexities of lived moral experience, asking a broader range of ethical questions, understanding “ethics” as socially and culturally situated, and ensuring their own critical reflexivity *vis-à-vis* bioethics' projects, positions, and partnerships [13,14].

In this article, we bring the sociological literature to bear on the ethical questions of posttransplant pregnancies in order to cultivate a more robust picture of the experience of posttransplant pregnancy, the social forces that inform those experiences, and the moral dilemmas inherent in those experiences. We outline the current posttransplant pregnancy research and suggest areas of future research. We begin with a discussion of prepregnancy counseling, and then detail issues surrounding postpregnancy quality of life and posttransplant mothering. Ultimately, we hope to cultivate an expansive understanding of the ethical dimensions of “best practice” in the area of posttransplant pregnancies. The “success” of posttransplant pregnancy should not be allowed to overshadow the real risks entailed by these pregnancies, the many unanswered questions about this endeavor, and the contingent health and fluctuating quality of life experienced by transplant recipients who, by the auspices of transplant medicine, have now become parents.

Clinical risks for posttransplant pregnancy

End-stage organ failure regularly produces infertility in reproductive-aged women [1,2,4], yet fertility often (although not always [2]) returns post transplant. However, gestation after transplantation should be labeled “high risk” [3] due to associations with obstetrical complications. As outlined in a growing body of literature, the risks vary according to the type of organ transplanted, the original disease or disease process, the time between transplant and conception, the immunosuppressant drug regimen followed, and the recipient's current health status [10–12].

^e A 2006 study of US transplant centers found 15.3% of responding clinicians recommended organ recipients to avoid pregnancy completely. The remainder recommended recipients avoid pregnancy for some duration prior to or following transplant [20].

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