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Maternal Decision-making During Pregnancy: Parental Obligations and Cultural Differences

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Decision-making during pregnancy can be ethically complex. This paper offers a framework for maternal decision-making and clinical counseling that can be used to approach such decisions in a systematic way. Three fundamental questions are addressed: (1) Who should make decisions? (2) How should decisions be made? and (3) What is the role of the clinician? The proposed framework emphasizes the decisional authority of the pregnant woman. It draws ethical support from the concept of a good parent and the requirements of parental obligations. It also describes appropriate counseling methods for clinicians in light of those parental obligations. Finally, the paper addresses how cultural differences may shape the framework's guidance of maternal decision-making during pregnancy.

Introduction

Pregnant women today face an array of decisions during pregnancy. Better understanding of embryonic and fetal development has offered insight into the effects of choices about nutrition, medications, and other substance use. Genomic and genetic innovation and improved imaging allow prenatal diagnosis that can be used to inform decisions about pregnancy termination or appropriate intervention. Fetal therapy is now an option for a variety of conditions that previously entailed certain morbidity and mortality. Finally, fetal monitoring and new surgical delivery options are changing the

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way pregnant women prepare for birth. This list excludes related questions about how and when to conceive and any medical intervention that might be appropriate after a baby is born.

New knowledge and technology hold great potential to improve the well-being of both women and fetuses and create new options that can raise challenging questions about whether, when, and how to employ such knowledge and technology. Therefore, pregnant women and their health care providers face an expanding set of decisions as a routine part of prenatal care when pregnancy progresses normally and an even more complex array of options when concerns arise. In this review, questions of who should make decisions during pregnancy and how those decisions should be made are explored. The role that a clinician should play in these decisions and ethical justifications for various counseling approaches are described. Finally, strategies for negotiating cultural differences are presented.

It is worth clarifying from the outset that the vast majority of these decisions are not governed by legislation in most countries (with some notable exceptions such as elective pregnancy termination). In contrast, many of the world's religions do offer direct or indirect guidance about what a woman should or should not do during pregnancy. Religious beliefs and perspectives are therefore likely to have a considerable impact on the decision-making processes of some pregnant women. Although law and religion may inform or influence these decisions, the focus of this review is not on legal or religious considerations but on the *ethical* aspects of decision-making during pregnancy.

A Case to Consider

> Mrs. S is 31 years old and 20 weeks into her first pregnancy. During the routine anatomy scan performed at 19 weeks, a thoracic myelomeningocele was found. Mrs. S was referred to a nearby fetal therapy center for further evaluation where MRI confirmed the ultrasound finding and revealed a Chiari II malformation of the brain. No other congenital anomalies were identified, and the baby's karyotype was normal. Dr. Y explained the condition to Mr. and Mrs. S and described two different treatment approaches: fetal surgery or postnatal repair. Although postnatal repair is the standard of care, limited available research has shown improved outcomes for children undergoing *in utero* surgical repair. Fetal surgery, however, involves risk to the fetus and to the pregnant woman associated with both the surgery itself and future pregnancies.
>
> Mrs. S has decided that she wants to undergo the surgery to minimize the effects of the neural tube defect for her child. Mr. S, however, is strongly opposed. He does not believe that the available evidence of benefit to the child is sufficient to justify the risks to Mrs. S and the future children they hope to have. Dr. Y wonders how to proceed further.

Dr. Y's initial efforts should focus on answering questions and correcting any misunderstanding Mr. and Mrs. S may have. Once this has been accomplished, a number of ethical questions arise: Is the informed permission of both parents required for decisions that impact a fetus? Who is entitled to make this choice? What ethical considerations should guide the decision-making process? What is the appropriate role of the physician in that process?

Who should make decisions?

In Western society, we have a well-established ethical consensus that treatment decisions during pregnancy are left solely to the pregnant woman. A woman's right to determine what happens to her own body has such great moral weight that it overwhelms all other ethical considerations that might come into play. This position is built upon the bedrock of medical ethics: the requirement to obtain the informed consent of a patient undergoing medical intervention [1]. It is buttressed by considerations of justice, gaining support from the view that pregnant women are entitled to the same rights that other women are entitled to, including the right to make decisions affecting their bodily integrity [2]. Conflicting ethical norms including the interests of an intimate partner, the well-being of the fetus, and even the well-being of the pregnant woman are insufficient to upend the priority of maternal autonomy.

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