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Original Article

High-risk behaviours for the fœtus in pregnant women: The medicolegal and judicial aspects

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ABSTRACT

Pregnancy is a period of psychological change which may lead to difficulties of adaptation and psychological suffering and give rise to high-risk behaviours for the fœtus in pregnant women. These risk behaviours, which are defined by certain authors as a form of "maltreatment" of the fœtus, usually spring from the psychological distress of the pregnant woman but are not recognised as a specific medical disorder. We illustrate the difficulties encountered in the identification of, and the specific intervention in, these situations through the clinical case of a pregnant drugs-dependent patient subjected to several stress factors who, in addition to consuming substances, developed high-risk behaviours for herself and her pregnancy: self-endangerment under the influence of substances, falls or refusals of treatment. In our first part, we discuss the medicolegal possibilities afforded by French law to protect the fœtus in the event of the future mother's high-risk behaviours. In our second part, we discuss the successive evolutions of the legal status of the fœtus and pregnancy, and their consequences for medical practice and the clinical situations concerned. The lack of an answer concerning the designation of these behaviours, as either medical, legal or social acts, will prompt perinatal practitioners to a certain medicolegal prudence.

Introduction

Mrs K., 32 years, was hospitalised for dyspnoea in the gynaecology and obstetrics department of a French university hospital centre. She was 4 months pregnant with a girl. The patient had hypochondroplasia with poly-epiphyseal dysplasia, an autosomal dominant congenital syndrome manifested by dwarfism. Mrs. K. had been living in a couple for several years; both worked, and had no children yet. Her partner had no particular antecedents. A trophoblast biopsy performed the previous week for antenatal diagnosis identified the maternal genetic mutation in the fœtus, but in an attenuated form predictive of a reduced but normal size in adulthood. After interdisciplinary consultation, a medical interruption of pregnancy would have been accepted if the couple had requested it.

In interview, Mrs. K. revealed a serious medicinal polydependence, hitherto concealed, which she had had for several years (mainly benzodiazepines, which are morphine analgesics), with multiple relapses after withdrawal attempts. She complained of this dependence but had no genuine wish for change. We met the companion and re-interviewed the couple about their wishes concerning the pregnancy. She said she was undecided between continuing her pregnancy or requesting an abortion. He explained that in a recent marital conflict, his partner had announced her pregnancy to him, and at the same time threatened to commit suicide, and put herself in danger in a demonstrative manner. He

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said he refused to accept this child, whose prenatal development had been exposed to the mother's consumption of medication, entailing foreseeable deleterious effects despite reassuring medical explanations. He threatened his partner with a marital breakup if she did not put an end to her addiction.

Two weeks after this brief hospitalisation, Mrs. K. was re-admitted for dyspnoea, which led to the diagnosis of viral pneumonitis, complicated by medication-induced somnolence. She now agreed to give up the benzodiazepines and commit to a gradual reduction of her consumption over time, under outpatient medical supervision. With her agreement, her situation was presented to the medico-psychosocial staff of the maternity unit. We recommended a home-based care solution, to be performed by a midwife from the mother and child protection unit[1]. In the months following this hospitalisation, she cancelled or postponed most of her psychiatric and obstetrical follow-up appointments. During the few psychiatric follow-up appointments she did attend, she posed as a passive victim of her drugs addiction, and tended to seek to elicit negative countertransferential reactions, for example by saying ironically that she sometimes took her medication "with a glass of alcohol", while refusing to give any more details. Mrs. K. could very well be under the influence of drugs when the midwife visited her at her home and exhibit contradictory attitudes towards her pregnancy and her health. She informed her of her wish to give birth anonymously, and, on several occasions, contacted the administrative services of the Departmental Council to initiate the proceedings and then called them back to retract. She asked to be hospitalised for withdrawal treatment in a neighbouring *department* near her parents' home, and then quickly discharged herself against medical advice. The procedures for delivery by scheduled Caesarean section were explained to her and understood by her during an obstetric consultation she attended. A compilation of facts which were causing concern was drawn up and was also communicated to her.

One month before the date of delivery, Mrs. K. was hospitalised in the emergency department of the CHU for a suspicion of pulmonary embolism, and discharged herself against medical advice. A few days later, she met the pediatrician of the hospital's "Kangaroo" mother and child care unit for explanations on the procedures for her child's drugs withdrawal treatment. Mrs. K. then reaffirmed her intention to give birth anonymously, which she justified by refusing a child that she thought would be deformed because of the extent of her medication abuse, despite further reassuring explanations. A week later, just 2 to 3 weeks before delivery, the midwife reported an increase in the patient's consumption of substances to the medical-psychosocial staff and a series of increasingly serious accidents. Mrs. K. told the midwife that she had "fallen on her stomach on the stairs again", while refusing to specify the number of falls, and trivialising them. A few days later, alone in her car and under the influence of substances, she was involved in a minor road accident a few hundred metres after leaving home. In what she said to the emergency aid personnel, she trivialised the incident and quickly left to return home.

These events suggested a double endangering of life. Firstly, her own, with both the increases in her consumption and the road accident appearing in this context as suicide equivalents. And secondly that of the fœtus, and here we suspected the deliberate nature of the falls on her stomach or at least of the lack of precautions taken to avoid them recurring. We discussed the formal indication for hospitalisation on psychiatric grounds; this decision, together with its modalities, were indicated in the report made out by the medical-psychosocial staff, and recorded in the medical file. Mrs. K. was quickly brought to the obstetrics and gynaecology department by the midwife for voluntary hospitalisation, to enable both obstetrical and psychiatric care. Mrs. K. gave birth anonymously and then reversed her decision a fortnight later, leading to the separation of the couple. The father did not recognise his daughter. During the social inquiry which was undertaken as a matter of urgency, Mrs. K. applied for an administrative placement of her daughter with her parents, who were named as trusted third parties.

In this clinical situation, the fœtus was exposed to several events pertaining to "fœtal maltreatment", which Diquelou [1] defines as a set "of physicochemical trauma, of acts of serious negligence causing a distortion of development, or a lack of parental interest or investment which impairs the emotional environment surrounding the birth". Following the nomenclature used by Soulé and Soubieux [2] and Tabet et al. [3], we distinguish here between on the one hand "active mistreatment" – falls on the stomach, consumption of toxic substances and repeated refusals of care – and on the other hand "passive maltreatment" – failures to accept both the obstetrical follow-up of a high-risk pregnancy and psychiatric care, self-discharges against medical advice, and the lack of medical treatment after falls. The voluntary nature of the falls is only suspected, since physical violence against the fœtus is generally difficult to detect [4]. Quite apart from the specific difficulties related to substance abuse during pregnancy, this situation differs from those usually encountered by virtue of the lack of guilt that was expressed with regard to the fœtus and the subject's failure to make any attempt to control her consumption, even actually increasing it. Each time, the patient was informed of the risks involved for her and her fœtus, and the information was recorded in the medical file.

This clinical case leaves us to face a major difficulty related to the endangerment of the fœtus. What bodies of knowledge and what legal provisions are there to help us in our reflections on this type of situation? We shall see in what ways medicolegal possibilities afforded by French law provide for intervention in cases where pregnant women display high-risk behaviours for the fœtus, and what implications the legal status of pregnancy and the fœtus has for medical practice in this type of clinical situation. We prefer the terminology "high-risk behaviours for the fœtus" to "fœtal maltreatment": in our view, the term "maltreatment" pertains to voluntary and conscious actions and implies connotations of guilt; we believe that the terminology "high-risk behaviours" corresponds more closely to the notions of maternal ambivalence and psychic suffering.

Medicolegal possibilities for intervening in cases of pregnant women displaying high-risk behaviours for their fœtus

Generally speaking, the high-risk behaviours of pregnant women for the fœtus which constitute a form of "maltreatment" arise from psychological distress in the pregnant woman, and it is prudent to recall that pregnancy may be the cause of psychological or even psychiatric difficulties in any woman. There is no specific clinical recognition of these situations in the ICD-10 and DSM-V classifications, and publications on this subject are rare. Tabet et al. [3] speak of "states of shared suffering" between the fœtus, the mother, and the family circle, and conclude with three objectives:

- the prevention of situations generating a risk of maltreatment;
- the recognition and understanding of this suffering;
- the need for treatment.

We detail here how these recommendations may draw support from the French child protection system and what the limits of this system are.

[1] The mother and child protection unit is a service in charge of providing health protection for the mother and child, and which organises consultations and preventive medicosocial measures for pregnant women and children under 6 years of age.