Addiction during pregnancy: How can specialists balance maternal autonomy and fetal health?

May 8, 2015

Editor's Note: This Op-Ed/Editorial was written by Marjorie Meyer, MD, a Maternal Fetal Medicine subspecialist at the University of Vermont Medical Center. This piece is part of our month-long Special Series on Motherhood and Addiction.

Healthy Mom = Healthy Baby. As a maternal fetal medicine subspecialist (an obstetrician who cares for high risk pregnancy), this is the motto. The interdependence of the health of the mother and baby is most apparent during pregnancy, but extends through the life of each individual after birth. So why are we at a time when fetal rights seem to be at odds with maternal rights?

Mothers are not perfect – ask any child. Specific maternal behaviors have well described effects on the newborn: maternal obesity is associated with larger infants who are themselves at risk for obesity; smoking is associated with preterm birth and smaller infants; alcohol use is associated with malformations and abnormal fetal brain development; and illicit substances can cause preterm birth, still birth, and, from opioids, a neonatal opioid withdrawal syndrome.

It seems obvious that these behaviors should be modified for the health of the newborn. Indeed, many women are motivated to change their health behaviors when pregnant: they eat healthier food, reduce smoking, and seek drug treatment. Those pregnant patients lucky enough to have access to the tools for health improvement– the food, counseling and medications that facilitate behavior change – can improve the health of themselves and their neonates.

But addiction is a chronic, relapsing disease. Not all patients are ready for behavior change, even with a pregnancy to consider. Diabetics eat cake; smokers sneak a cigarette, alcoholics slip and drink, and opioid addicts use illicit opioids. Of these groups, however, it has been the pregnant patient using illicit substances who is at risk for loss of her autonomy through incarceration on behalf of her fetus.

It is only natural that physicians may also feel an ethical obligation to the fetus

when treating addiction during pregnancy. How can this dilemma be resolved?

The American Congress of Obstetricians and Gynecologists (ACOG) has worked with ethicists and the American Society of Addiction Medicine to assist physicians who feel torn between fetal and maternal rights.

ACOG endorses the same basic ethical tenets used for medical care exist for the treatment of unhealthy behavior during pregnancy:

> **Beneficence**: We have an ethical obligation to treat addiction as a medical disease rather than moral failing. Effective treatments are available and should be provided during pregnancy.
>
> **Nonmaleficence**: We have an ethical obligation to do no harm. We can harm pregnant women by using humiliation or shame, as it creates a barrier to treatment and recovery.
>
> **Justice**: This principle governs access to care and distribution of resources. Pregnant women should have access to addiction treatment, including referral to appropriate resources and medication.
>
> **Respect for Autonomy**: The issue of autonomy is particularly difficult during pregnancy. While patients may have a moral obligation to act in a manner that is to the benefit of the fetus, as health care providers, our ethical obligation is to develop a trusting relationship with the patient and assist her in achieving this goal. Patients who fear repercussion of admitting to an addiction problem will not seek help.

Yet, we find our ethical tenets have collided with our legal system. Fifteen states require health care professionals to report suspected drug use and four require biochemical testing for prenatal drug exposure if they suspect abuse. One state allows criminal prosecution for use of illicit substances during pregnancy (Tennessee, under a law passed in 2014); 18 states consider drug abuse during pregnancy to be child abuse under civil welfare statues, and 3 states allow involuntary civil commitment (residential treatment programs) (see more here). It is difficult for those of us treating women for substance use disorders during pregnancy to uphold both ethical and legal obligations.

ACOG and the American Society of Addiction Medicine both endorse strong statements in support of maternal autonomy and against forcing treatment of the

mother, incarceration during pregnancy on behalf of the fetus, or loss of maternal autonomy in decision making. Both stress that a punitive approach may reduce disclosure of substance use and prevent women from seeking prenatal care or treatment. Both acknowledge the improved outcomes of pregnancy when women are treated for substance abuse during pregnancy. Both have advocated for legislators to demonstrate restraint in the use of the legal system as a mechanism to impose treatment during pregnancy and for physicians and legislators to work to rescind punitive laws.

So what is the responsible physician to do?

This is a good time to consider how physicians feel about the ethical obligations to the mother and fetus. Despite the strong statements from their respective professional groups, addiction specialists may feel uncomfortable in this balance of maternal autonomy and fetal health. They are not alone: obstetricians and pediatricians must balance maternal autonomy and fetal health in invasive fetal care, when access to the fetus is impossible without corresponding maternal intervention. Consider the case of a fetal anomaly that might be treated during pregnancy. Such treatment entails a procedure the mother may endure (some minor, some major with long term maternal consequences). Treatment may improve outcome for the fetus, but create risk for the mother. How to obstetricians and pediatricians feel about the autonomy of maternal decision-making regarding fetal therapy?

Four hundred obstetricians and pediatricians were asked about the role of a court order in mandating maternal treatment in 3 specific scenarios in which maternal treatment would improve the fetal outcome: treatment for cocaine addiction, maternal mediation treatment for HIV (which would reduce transmission of HIV to the fetus), and in utero transfusion for fetal anemia (a procedure performed on the mother to access the fetal circulation). Pediatricians were more likely than obstetricians to endorse court order for each treatment scenario. Physicians with self-admitted strong religiosity were also more likely to feel that seeking a court order was appropriate.

The importance of this type of study is that it underscores the difference between our policy statements and our personal opinions. The ACOG Committee on Ethics and the American Academy and of Pediatrics Committee on Bioethics wrote a joint statement upholding the importance of maternal autonomy. As health care

providers, we should accept and embrace that our feelings and values might differ from our professional ethical obligations. I am unaware of such exploration of the emerging ethics of the treatment of substance abuse during pregnancy with obstetricians and addiction specialists, but it could be helpful to explore.

A major recommendation from this joint statement regarding the approach to a dilemma in fetal care could be applicable to substance abuse treatment as well: "Because it is impossible to treat the fetus without going through the pregnant woman either physically or pharmacologically, any fetal intervention has implications for the pregnant woman's health and necessarily her bodily integrity and, therefore, cannot be performed without her explicit informed consent."

Another area of consensus is the importance of maternal treatment. Legislators have assisted health care providers greatly in some states: 19 states have either created or funded drug treatment programs specifically for pregnant women and 11 specifically provide priority access to treatment programs for pregnant women. In Vermont, physicians and the legislators have worked collaboratively to improve access to treatment that develop extends into the most rural areas of the state.

Addiction is a treatable disease. Health care providers have a professional and ethical obligation for the best treatment for the mother, recognizing this approach is congruent with the best treatment of the fetus. All women deserve treatment for substance abuse with the same evidenced-based treatment as non-pregnant women (and men), which may include no treatment until they are ready. Obstetric and addiction health care providers must continue to share a strong voice in support of maternal autonomy and eliminate legal barriers that prevent women from seeking help for addiction during pregnancy.

-Majorie Meyer

What do you think? Please use the comment link below to provide feedback on this article.

Marjorie Meyer has been treating women with opioid dependence during pregnancy since 2004 and was a co-investigator in the MOTHER study (Vermont PI: Sarah Heil). She has been a buprenorphine prescriber and has been involved in numerous panels examining the treatment of opioid dependence during pregnancy. She is currently a co-investigator in an NIH sponsored study

examining the use of long acting contraception in opioid dependent women (PI: Heil).