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Ethics in Obstetrics: Revisited

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Abstract

Obstetrics is a speciality dealing with two lives, closely linked, whose interests may not coincide. Due to rapid expansion of medical technology, obstetricians have to face complex ethical questions. Surrogacy has given a new dimension to the concept of a traditional family. Surrogacy offers hope to couples to produce their own genetic family. Fetal therapy is an exciting new field of expertise with expanding indications. The medical community is benefitted by these innovative therapies. The greatest care should be taken in explaining findings of congenital malformations to the parents, sympathetic approach, understanding and reassurance are important.

Keywords: Ethics; Surrogacy; Fetal therapy; Congenital Malformations; Counselling.

INTRODUCTION

Obstetrics is a unique speciality dealing with two lives, closely linked, whose interest may not coincide. In view of human rights, balancing rights against each other is essential. The right to the life of the mother and that of the fetus is the same.[1] Over the past 50 years, medical technology expanded rapidly, so obstetricians have to face complex ethical questions. In addition to medical knowledge, responsible decisions depend on values, goals, rights and obligations of those involved.[2]

It is beyond the scope of this article to discuss all the aspects of ethical issues in obstetrics. Thus, in this article we have discussed the following emerging issues in obstetrics:

- Surrogacy
- Fetal Therapy
- Fetal Congenital Malformation
- Fetus and Bioethics
- Reproductive Healthcare

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DISCUSSION

Surrogacy

Surrogacy is both the oldest and most controversial of reproductive innovations. This technology has given a new dimension to the concept of traditional family. It has separated genetic and gestational links between parents and children and has also created distinction between social relationships and interpersonal ties within families.

In surrogacy difficulty revolves around the fact that, for many years the birth mother has been considered as the real mother. This has been revised to accommodate the surrogacy situation, the legal aspect of the mother must be precisely clarified before IVF surrogacy is considered. Some of the ethical issues identified include the separation of genetic, gestational and social/interpersonal links between parents and children. In the international setting of surrogacy commissioning couples enjoy the freedom with added benefits of significant savings and reduced likelihood of gestational carriers claiming maternal rights to the child. Surrogacy offers hope to couples to produce their own genetic family. There should be direct evaluation and monitoring of all the procedures involved in care of these patients.[3]

Fetal Therapy

The Embryo or Fetus of any age is Protected by Hippocratic code:

"I will maintain the utmost respect for human life, from the time of conception."

Every human has the inherent right to life. When does a developing embryo becomea person? It is extremely difficult to draw the line and say that developing zygote or fetus becomes a person from a particular time. Damages are claimed, if an injury is caused to the fetus in the womb which means that fetus is a person. Can the life of a person be ended by procedures by others?[4]

Fetal therapy is the branch of fetal medicine including a series of interventions performed on the sick fetus with the aim of achieving optimal fetal well-being.

Parents have to be Counselled on:

- Maternal and fetal risk
- Type of interventions
- Cost and hospital stay

Fetal therapy is a cause for concern because of:

- The invasive nature of these procedures
- The lack of sufficient data regarding long-term outcomes
- The medical/ethical uncertainties associated with some of these interventions.

For all interventions, parents are counselled by specialists.[5]

	For fetal therapy, the following ethical concepts should be considered:
1	Respect for the autonomy of the pregnant woman
2	Respect for the fetus as a patient
3	Respect for the individual conscience of the physician

Counselling and informed consent of pregnant women for fetal therapy is of vital importance. This hope is often created by a number of factors including:[6]

- Advice and counselling
- Wishes of her family
- Her socio-economic circumstances
- Legal considerations.[7]

Any counseling session must include a balanced discussion of the uncertainties, complications, and failures of the therapy. A provider's failure to fully disclose uncertainties, complications, and alternatives of fetal therapy might result in subsequent disappointment and resulting litigation and claims.[8]

Health care providers should provide the pregnant woman with adequate information regarding:

- The nature of the fetal condition
- A realistic prognosis
- Potential complications associated with the main anomalies/illness
- The required or preferred mode of delivery, the recommended place of delivery
- Appropriate level of care following delivery (hospital, home or perinatal hospice).

In cases where there is a lethal anomaly for which palliative care only is recommended, the focus of

the care plan should be the pregnant woman. It is important that when such decisions are made, adequate grief counselling and support services should be made available to help the patient and her family deal with a stillbirth or neonatal death.[9] Over the past four decades there is a transition of fetal therapy from experimental observation into standard of care and clinical reality.[10]

Fetal therapy can be direct or Indirect:

Indirect Fetal Therapy

- Treatment given to the mother

Direct fetal Therapy

- Maternal therapy for treatment of fetal condition
- Fetal transfusion
- Intervention in TTTS
- For therapy or fetal medication
- Fetal surgery[11]

In some cases, intervention before birth may be desirable, often not requiring direct access to the fetus, e.g. transplacental administration of antibiotics in case of fetal infection or anti-arrhythmic drugs in case of arrhythmias.

Maternal side effects as well as the potential impact on future reproduction and pregnancies should be well studied and discussed. Maternal consent for any fetal therapy is necessary.[12]

FETAL CONGENITAL MALFORMATIONS

Congenital anomalies of fetus:

The obstetrician's role in providing routine antenatal cases is to reduce maternal and perinatal mortality while preserving maternal satisfaction with pregnancy. While fetal anomalies are more common in certain high risk groups, the vast majority of anomalies will not be anticipated. Certain manifestations can be treated in utero or postnatally. Therefore ethically, early diagnosis can facilitate decision making regarding mode and place of delivery.[11]

Parents have a desire to have a child of certain quality. The finding of some "Abnormality' in pregnancy transforms what was previously a joyful event into distressing time.

The identification at an early gestation of abnormalities incompatible with survival or likely to result in severe handicap enables the obstetrician to prepare parents and offer the option of termination of pregnancy. The greatest care should be taken in explaining findings of congenital malformations to parents. Sympathetic approach, understanding and reassurance are important. The parents must decide what action they wish to take. It is our role to advise, guide and respect their final wish, irrespective of our personal views. In obstetrics practice, the strength of counselling for benefit should vary according to presence and severity of fetal anomalies.[1]

Anencephaly

When fetal anomalies such as anencephaly are diagnosed, what is ethical? Such patients are dying patients and counselling is important. As anencephalic infants don't survive, these women are offered the option of MTP.

RIGHT TO LIFE

"I will maintain the utmost respect for human life, from the time of conception."

Termination of pregnancy brings out conflicts between the rights of two people: the rights of mother and the rights of child in the womb. Does the mother have the right to destroy the child in thewomb? Does the unborn child have the right to life? Is the doctor right to kill the child in the womb at the request of the mother? Parents have the desire to have a child of certain quality. Fetus in-utero is not able to consent or refuse medical treatment to sustain life or allow its termination. Can death be a legally valid choice in case of a severely disabled or malformed baby?

Is it ethical to declare organ donor status for anencephalic newborns on the basis of prenatal diagnosis and, with parental consent, to procure the organs before the infant died of its neurological devastation?[12]

The American Medical Association (AMA) concluded that with prior consent of the newborn's parents, it was ethically acceptable to transplant the organs of anencephalic neonates without waiting for them to die naturally.

It is essential that multi-disciplinary team gives information about:

- Prognosis
- Impact of the condition for the future child
- Family environment

- Need and availability of structured medical and educational support
- Benefits and harm of interventions
- Possible alternatives

The physician has to respect the autonomous decision of the pregnant woman.[13]

FETUS AND BIOETHICS

Ethics has always formed the basis of good practice in and rights medicine. In recent years ethical issues have gained more importance in public eyes, due to several significant developments. In simple words medicine when practiced at its best, seeks to do what is right and good, and ethics help in defining and achieving that goal.[14]

These days the fetus has been given individual status and rights. In obstetric practice, it is essential to promote and protect interests of both the pregnant mother and her fetus. With advent of modern technologies and emerging branch of fetal medicine, obstetricians have to face ethical dilemmas related to many fetal issues.[15]

Ethics and Reproductive Healthcare

Ethics is defined as the science and practice of mortality which translates into behaviour towards subjects under care, it means acting in the best interests of patients being cared for. Healthcare providers fulfill a basic need to preserve and advance the health of all human beings. Obstetricians and Gynecologists looking after the issues relating to reproductive health care of women develop relationships with their patients involving mutual rights to promote health in an environment of mutual respect, honesty and trust.[16]

Mutual trust is at the heart of a doctor patient relationship. It is important to maintain the relationship of trust between Doctor and Patient. Competence, compassion, care and good communication are central. Patients must be treated with respect, be properly informed, give their consent voluntarily and have their confidentiality fully respected.[17]

MORAL OBJECTIONS OF PHYSICIAN

In cosmopolitan society moral views may differ. This is important in the field of reproductive healthcare, where patients may seek advice regarding sexually transmitted diseases, contraception, prenatal diagnosis, unwanted pregnancies and others. If the discussion of certain treatments is violative of the physician's moral values, he or she is not obliged to provide such services. However, the patient should not be deprived of her reproductive options. She should be referred elsewhere for the services she desires.

Confidentiality:

This is essential to the trust required for an effective patient-physician relationship. It is particularly important in the field of reproductive healthcare where private issues are disclosed. The patient has the right to decide when and with whom her medical records may be shared. Sometimes, confidentiality risks harming a third party like in case of STDs, presence of hereditary genetic disorders, predisposition to violence or psychiatric disorders. Usually patients do agree to share information when explaining its importance for the health of others.

Sterilization:

Sterilization is an elective procedure with permanent and far reaching consequences. Physicians who perform sterilization have ethical responsibilities to counsel patients fully and without bias. They must also be aware of the limitations among patients with impaired mental abilities to participate fully in the informed consent process. In such situations, their caretakers must be taken into confidence before making decisions. It is vital to realize that the tubal reanastomosis procedure has been known to fail. In addition, there is also the possibility of separation in a marriage or remarriage which may bring in newer demands. Puerperal tubal ligation is also not free of morbidity. Women with young children desirous of tubal sterilization should also be counselled for alternative methods of contraception and to delay the decision of surgical sterilization until the children have grown up.[16]

Oncofertility:

Oncofertility is the term especially designed for options that expand the possibilities of reproduction in cancer survivor patients. Cancer treatment either by chemo or radiotherapy or surgery may destroy the patient's ability to have children in later life. Oncofertility research focuses on such issues that may increase fertility preservation options. It is a major societal issue in clinical practice.

Oncofertility involves reproductive issues after cancer treatment such as:

- Family planning
- Contraception
- Hormonal management
- Surrogacy
- Adoption

Fertility options for women

Options for women to have children after cancer treatment have increased significantly in recent years. Women should be counselled about established methods like:

- ***Egg Banking:*** Hormonal stimulation causes production of multiple eggs which are removed and frozen for future use.
- ***Embryo Banking:*** Hormonal stimulation causes the production of multiple eggs which are removed, fertilized by sperm and frozen for future use.
- ***Ovarian transposition and shielding:*** Ovaries can be surgically removed or shielded from areas receiving radiation.
- ***Surrogacy:*** After sterilizing cancer treatment women can also choose surrogacy where a woman carries a pregnancy for another woman or couple.
- Adoption

Ethical counselling is one of the most important issues in this matter.[18]

ADOPTION

Adoption is a commonly used alternative strategy for establishing a family. Although adoption is not a medical event, the gynecologist treating infertility is often looked up to for guidance by couples who do not succeed in their mission. Physicians commonly provide information, counsel and guide the prospective adopting parents to adoption agencies without playing role of broker. Physicians should involve themselves in counseling and screening roles and as facilitators with great care because potential exists for unintended misuse of confidentiality and patient autonomy leading to compromise of the patient's best interest by subtle or blatant conflicts of interest. It is advisable to delegate duty to an independent authority including all responsibility for matching pregnant women with prospective adoptive parents.

Six principles have traditionally guided adoption practices worldwide. These include:

1. Consent of the birth mother, whereas presumed waiver by absent father has been accepted as routine.
2. The purpose of adoption was to serve the child's best interests by placement with suitable adoptive parents.
3. Adoption practices were based on the principle of gratuitous transfer and financial transactions suggestive of purchase of a child were prohibited.
4. Relations with adoptive parents were expected to substitute entirely relationships with biological parents.
5. Relinquishing birth mothers and adoptive parents were assured that their confidentiality and anonymity would be maintained.
6. Adoptive relations were presumed to be permanent after final court approval.[16]

Ethics of Research in Reproduction

The ACOG committee on ethics has made the following recommendations for research involving pregnant women.

I. All research on pregnant women should be conducted in a manner consistent with the following ethical principles:

- It should conform to general scientific standards for research.
- Efforts should be made to avoid any financial or nonfinancial conflicts between appropriate health care and research objectives.
- Researchers should not offer inducements, financial or otherwise; designed to influence participation in research, beyond reasonable compensation for the pregnant woman's time and expenses.
- Health care needs of the individual patient should always take precedence over research interests in all situations affecting clinical management.

II. Research involving diagnostic and treatment modalities for either the pregnant woman or the fetus should conform to the following:

- To be conducted only with the informed consent of the patient.
- Be evaluated for its potential impact on

the fetus and that the evaluation should be communicated to the patient as part of the informed consent process.

- Be conducted only when the alternative modalities available within the study are considered to be: (a) therapeutic equivalents or (b) superior to the alternative of not participating in the study.
- Research that does not have the potential therapeutic value to either the pregnant woman or her fetus is not appropriate if either might be placed at more than minimal risk.[16]

GENETIC COUNSELLING

Genetic counselling is understanding and adaptation to medical, psychological and familial implications of genetic contribution to disease.

The process Integrates:

- Interpretation of family and medical histories to assure the chances of disease occurrence or recurrence.
- Education about inheritence testing, management and prevention resources.
- Counselling to promote informed choices and adaptation to the risk or condition.

Genetic counsellors act as co-ordinator between physicians and patients as well as genetic resources to physicians. Genetic counsellors provide information and support to families who have members with birth defects or genetic disorders and to families who may be at risk of inherited conditions.

Patients

Any person may seek out genetic counselling for a condition they may have inherited from their biological parents. Testing enables women and couples to make a decision as to whether to continue or terminate a pregnancy. A person may undergo genetic counselling after birth of a child with a genetic condition. The counsellors explain the condition to the patient along with recurrence risks in future children.

Families or individuals may choose to attend counselling or undergo prenatal testing for a number of reasons:

- Family history of genetic condition or chromosomal abnormality
- Molecular test for single gene disorder
- Increased maternal age (35 years and older)
- Increased paternal age (40 years and older)
- Abnormal maternal serum screening results or USG findings
- Increased nuchal translucency on USG
- Strong family history of cancer
- Predictive testing for adult onset conditions

CONDITIONS

Disorders like cystic fibrosis cannot occur unless both mother and father pass on their genes.

Some diseases, however, can be inherited from one parent, such as:

- Huntingtons disease
- DiGeorge syndrome

Other genetic disorders are due to errors or mutations during the cell division process.

Genetic tests are available for a number of genetic conditions like:

- Down's syndrome
- Sickle cell anaemia
- Tay-Sach's disease
- Muscular dystrophy[18]

CONCLUSION

Surrogacy has given a new dimension to the concept of traditional family. The maternal side-effects of fetal therapy as well as the potential impact on future reproduction and pregnancies should be well studied. The moral status of a fetus is perceived to be the same as that of a neonate. This implies that a fetus is a patient and can be considered independent from the mother with a right to therapy. Obstetricians have a duty toward the fetus who will then become a baby. The mother becomes the moral agent in relation to making choices on behalf of the fetus. Great care should be taken in explaining the findings of congenital malformations to the parents. A sympathetic approach, being understanding and reassuring is extremely important.

REFERENCES

1. Alka Patil, Sayali Thavare, Bhagyashri Badadde, Congenital Malformations of fetus Obstetrician perspective, Indian Journal of Maternal, Fetal and Neonatal Medicine, Vol.6 No.2 July – December 2019.
2. Ethical decision making in obstetrics and Gynaecology committee opinion No. 390; December 2007.
3. Kaushal Kadam, Namrata Rajput, Joshi Kalika, Mandakini Megh Playing by the rules – An update on Government policies, Regulations and Acts for practicing obstetricians and Gynaecologists. Edition 2015 CBS publishers.
4. CM Francis. Right to life. Medical ethics Jaypee brothers Delhi 2004 edition.
5. Chervenak FA, McCullough LB. Ethical issues in recommending and offering fetal therapy. West J Med. 1993 Sep;159(3):396–9.
6. Chervenak FA, Mccullough LB. Clinical Opinion An ethically justified practical approach to offering, recommending, performing, and referring for induced abortion and feticide. YMOB. 2009;201(6):560.
7. Williams C. Dilemmas in fetal medicine: Premature application of technology or responding to women's choice? Social Health Illn. 2006; 28(1):1–20.
8. Spatz ES, Krumholz HM, Moulton BW, KD H, D S, G E. The New Era of Informed Consent. JAMA. 2016 May 17;315(19):2063.
9. Deepika Deka, Pankaj Desai, Narendra Malhotra; Fetal therapy: Medical and surgical; Page 1410, Chapter 30; Principles and practice of obstetrics and gynaecology for PGs; Jaypee Brothers, Edition 4/e; 2014.
10. V, Boyle F, Koopmans L, Wilson T, Stones W, Cacciatore J. Meeting the needs of parents after a stillbirth or neonatal death. BJOG. 2014 Sep;137–40.
11. Sudha Salhan Sunita Seth Indhira Ganeshan prenatal diagnosis and fetal therapy, Sudha Salhan Textbook of Obstetrics Jaypee Delhi, Second edition 2016.
12. Deprest J, Toelen J, Debyser Z, Rodrigues C, Devlieger R, De Catte L, Lewi L, Van Mieghem T, Naulaers G, Vandevelde M, Claus F, Dierickx K. The fetal patient -- ethical aspects of fetal therapy. Facts Views Vis Obgyn 2011;3(3):221-7.
13. The American Medical Association's code of Medical Ethics: The living code, Fetal congenital Malformations, Ethical issues in organ donation by anencephalic neonates, Vol 6, No.8 August 2004.
14. Sanjay Gupte. Ethical Issues in Gynaecology & Obstetrics Dasgupta, Recent Advances in Obstetrics & Gynaecology Jaypee 2003.
15. S. Soundara Raghovan, Ethical Issues, Asha Qumachigui, Essential Obstetrics University Press, Hyderabad.
16. Shirish Daftary, Shyam Desai Ethics and Reproductive Healthcare, Shirish Daftary Shyam Desai Selected topics in Obstetrics and Gynaecology - 5, BI publications New Delhi 2009.
17. Mandakini Megh-How to become a good Doctor: Ethics in Obstetrics and gynaecology, Pankaj Desai, Narendra Malhotra, Duru Shah. Principles as a practice of Obstetrics and Gynaecology Post-Graduate. Jaypee Brothers Delhi 3rd Edition.
18. Motilal Tayade Oncofertility, Motilal Tayade Textbook of Medical Bioethics Attitude and communication for Medical students, CBS Publications New Delhi 2016.