# The Fetal Maternal Conflict: One Body, Two Considerations

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The scenario surrounding a pregnant woman provides a unique and complex situation in which the rights of both mother and fetus must be considered. Conflict arises when a mother's decision regarding her pregnancy may cause harm to the fetus. Controversy in the fetal-maternal conflict appears in circumstances regarding a woman's personal health care choices, lifestyle and behaviors, and occupational situation (Flagler et al. 1997). One perspective on this issue is that a pregnant woman has reproductive rights and should maintain autonomy over her own body. The opposing perspective believes that a woman's reproductive rights do not outweigh the fetus's right to live. This conflict places physicians and their health care team in a difficult bioethical situation where they must consider both patient and fetus well-being. Differing laws and standards exist to uphold certain ethical decisions. Although a woman's autonomy is an essential right, the considerations of human anatomy, politics, religion, and human rights interact in the controversy surrounding the fetal-maternal conflict supporting a woman's responsibility to her fetus when bringing her pregnancy to term.

The term fetal-maternal conflict is a widely used medical categorization amongst health care professionals. However, the wording itself suggests that a mother is in conflict with the fetus in her own body. The connotation of the term becomes problematic when, in actuality, the well-being of mother and fetus are inextricably linked. Many times, the issues that arises via the fetal-maternal conflict comes from a third-party source, often serving to protect fetal rights. This outside source imposing opinions on a mother's decision may be child welfare agencies, physicians, family members, or even the views of society (Flagler et al. 1997). Social groups arising from religion, culture, family, and friends can impose expectations on individuals in their pregnancy. A woman may feel influenced by aspects in her life that are unclear to health care

teams. Despite what the term suggests, the fetal-maternal conflict encapsulates a medical situation where the well-being of the mother and her developing fetus must be considered together.

An extremely controversial topic that plays a role in the ethical considerations of the fetal-maternal conflict is when life begins. This concept is essential for ethically assessing if the life of the fetus holds equal importance to the mother. Differing religious teachings establish various answers to this complicated question. Jewish religious law, Halaka, gives full status of humanness to a child at birth. Some teachings from the Talmud extend full acquisition of humanness to 13 days after birth. The Babylonian Talmud considers the embryo to be water until the fortieth day of pregnancy. However, Judaism teaches that because a fetus holds the potential for human life it must be protected unless in a situation where the mother's life is in danger (Schenker, 2008). Catholic teachings differ in that they establish that life begins at conception.

Biology also plays a role in the conversation of human life. The American College of Pediatricians establishes that the fusion of maternal and paternal gametes marks the beginning of human life. They consider that each single-celled embryo created functions independently as an organism. The embryos are each genetically unique regarding their genome and will develop into the bodily feature of human life (2022).

This consideration of life as an embryo leads to philosophical ideas of what it means to be human, rather than an organism. Does being human mean that an individual has the ability to think and reason or are there more important considerations of humanness? One biological perspective on when life begins is described by the brain-life theory. Dr. Goldenring, a professor

of cell and developmental biology, suggests that the term “human being” is defined by the presence of an active human brain. He explains that the brain orchestrates all organs in the body and is the birthplace of human personality. This view marks the beginning of human life as the spectrum of development of the brain. The brain-life theory would categorize the onset of human life as the beginning of the development of the brain which occurs in utero at eight weeks gestation. Dr. Goldenring marks life as a unique functioning human beginning from the start of brain development until brain death (Goldenring, 1985). Applying this point of view to the fetal-maternal conflict allows the fetus to be considered a human with rights at eight weeks old. Different states use varying viability markers such as the first heartbeat to establish when life begins. Despite the controversy surrounding the topic of human life, situations involving the fetal-maternal conflict occur with a mother in the process of bringing her pregnancy to term. In the context of this issue, the health of a mother and her fetus holds equal importance and standing as human lives.

One of the most common issues regarding the fetal-maternal conflict is the concept of cesarean delivery. Cesarean delivery, or c-sections, is often a medically suggested form of delivery for mothers. This procedure entails an invasive abdominal surgery that maximizes a potential healthy outcome for birth. One out of three births in the United States is performed by cesarean delivery making it the most common surgical procedure in America (Deshpande, 2012). However, there are situations in which mothers choose to act against medical advice and proceed with vaginal delivery. The origin of this decision can come from a variety of different places. Women may be influenced by lack of education, fear of pain, language barriers, cost, and cultural and religious expectations. The CDC expresses that the cost of c-sections is twice

that of vaginal deliveries. Additionally, many hospitals have regulations expressing that women who have had c-sections in the past are not viable for vaginal delivery in the future (Desphnade, 2012). For many, this may be a major factor in decision-making as the cost of a child may already be overwhelming for families.

Another factor contributing to women declining cesarean delivery is race. Language barriers and cultural differences contribute to the statistic that 81% of women refusing c-sections were black, Hispanic, or Asian (Deshpande, 2012). This data is representative of how culture and language barriers can play a huge role in health care. Communication of procedures and outcomes may become misrepresented and unclear when in a second language. Another aspect of this conflict is how religion influences medical decisions. In many Arab cultures, cesarean deliveries are perceived as a form of mutilation. Among Hmong women, vaginal delivery is a necessity for their cultural beliefs (Deshpande, 2012).

Before criticizing the choices women make, it is important to analyze why these choices are being made. If a mother is choosing to bring her pregnancy to term, it is assumed that her baby is a priority in life. The reasons that mothers have for declining a surgery that would be beneficial for the baby go beyond bad morals or autonomy. These issues highlight the necessity of interdisciplinarity in health care teams. Surgeries must be properly explained to patients in a language and in terms that they are able to comprehend. Additionally, it would be beneficial for patients to have religious figures add perspective to their decisions. While a woman's personal beliefs are important, a fetus deserves the chance to be born as healthy as possible.

Another way the fetal-maternal conflict presents itself is within a woman's behavioral and lifestyle choices. The well-being of the developing fetus is linked to the way in which the

mother takes care of her body. A woman who is consuming proper nutrition and abstaining from unhealthy practices is more likely to have a healthy baby. One way this problem has presented itself in health care situations is through HIV testing. Dr. Flagler, a professor of medical bioethics, presents a case study in an article regarding the fetal-maternal conflict. She discusses a 19-year-old woman who is 25 weeks pregnant. During one of the patients' prenatal visits, she explains that her partner is bisexual and may have been exposed to HIV. Her physician explains that there may be treatment to reduce the chance of her fetus obtaining HIV. She explains to her patient that vertical transfer of HIV is a possibility for her fetus. However, the patient continues to refuse testing (Flagler, 1997). In this case, the mother's free will and right to privacy conflict with the best decision for the fetus. The baby deserves to be given the chance to enter the world free of disease. The mother has made the decision to put her fetus and future child in possible harm.

US courts have ruled that "a child has a legal right to begin life with a sound body and mind" (Ludwig, 2022). This right imposes a legal responsibility onto the pregnant woman to protect the health of her fetus. If her actions cause harm to her fetus, she may be charged with fetal abuse as well as being held liable for damage to her child. There have been legal cases where pregnant women have been challenged in regard to this right for refusal of hospitalization, intrauterine transfusion, or surgical delivery (Ludwig, 2022). These legalities relate back to a woman's behavioral and lifestyle choices. The child has the right to be born with a sound body, free of disease. The mother's right to free will in STD testing is forfeited when she decides to bring her baby to term.

Another extremely harmful decision a pregnant mother can make for her baby is drinking while pregnant. Fetal alcohol syndrome results from intrauterine exposure to alcohol. Children affected with this disorder may show signs of growth retardation, facial dysmorphology, central nervous system dysfunction, and neurobehavioral disabilities. This issue has continued to grow as the CDC reports that in 2015 10.2% of women reported binge drinking while pregnant (Denny et al. 2017). These statistics are extremely concerning as the health of our country's future children is being neglected. However, enforcing STD screenings, incarceration to prevent substance abuse, and forced obstetrical intervention can be very ethically and legally challenging. The concept of informed consent protects competent patients' rights to make their own medical decisions. Physicians acting against these decisions are at risk for criminal and civil liability (Flagler, 1997).

An opposing view to prioritizing fetal health over a mother's autonomy is evident in Canadian law. The Canadian Charter of Rights and Freedoms establishes that women and men have equal rights to life, liberty, and security of the person. However, it also states that the fetus does not have legal rights until after it is born. This categorization causes the fetus to not be protected under child protection legislation. The Manitoba Court of Appeal also ruled that there was no legal basis to force a pregnant woman to undergo mandatory counseling and hospital admittance to manage drug addiction. The Canadian Royal Commission on New Reproductive Technology recommends that a woman never be forced to have any procedure or counseling without her wishes. It also recommends that the conduct of a pregnant woman in relation to her fetus should not be criminalized (Flagler, 1997). These forms of legislation prioritize the mother's autonomy in her pregnancy. The basis of these laws circulates around

the idea that a fetus does not have rights until birth. This can be problematic when it is considered that the way a mother conducts herself during pregnancy affects the child even after it is born.

Although the perspective of prioritizing female autonomy can be detrimental to fetal health, there are positive aspects to this point of view. This position recognizes a woman's right to not have the state intrude on her life and more specifically her pregnancy. The Fourteenth Amendment "guarantees against state actions that intrude into the lives of individuals, restrict their autonomous decision making and infringe certain fundamental freedoms" (Farber, 1997). The Constitution also protects the right to procreation and childbearing. Emphasizing a woman's autonomy serves to allow her the freedom to make decisions about her body outside of being a mother. There are also cases where a mother's decision to go against medical advice does not harm the baby. Situations have occurred where a physician has suggested that cesarean delivery was medically necessary, and the patient continued to have a perfectly healthy vaginal birth (Flagler et al. 1997). Although prioritizing a woman's autonomy is important, a mother has a responsibility for the health of her fetus.

With the laws that exist regarding informed consent, it can be difficult for health care teams to protect the well-being of the fetus. One case study from The University of Washington's Bioethics and Humanities department describes how a health care team maneuvers the fetal-maternal conflict and all its complexities. This case study describes a 22-year-old woman with a normal prenatal course who presents with preterm labor at 28 weeks. A medication called terbutaline was successfully administered to cease contractions. A discharge plan was created for the mother, which included daily usage of oral terbutaline. The mother

reported that she could not comply as she had communicated with God. She felt that God would allow her labor whenever he was ready and that she should not use medication to conflict with God's plan (Ludwig, 2022).

This patient's care team was put in a situation where they must decide how to proceed to best benefit the mother and fetus. At 28-weeks' gestation, the fetus is at the border of viability, meaning it has a chance of survival outside of the mother's womb. The University of Washington's case discussion explains that the patient would participate in extensive non-coercive conversations with the care team to properly ensure that the patient understands the consequences of refusing her medication (Ludwig, 2022). This plan of action relates back to the notion of informed consent. Although her decision harms the fetus, the patient has the right to make medical decisions regarding her own body. The case discussion also mentions suggesting a meeting with a spiritual advisor who can more effectively discuss her personal beliefs and the impact on the baby. However, if the mother continues to refuse treatment, the care team may be forced to request a psychiatrist consultation to evaluate her competency. If the patient is found to be competent, then the ethical principle of nonmaleficence must be upheld. If the patient was found to be incompetent, the care team would have to consider judicial intervention (Ludwig, 2022).

This case study exemplifies the interdisciplinarity of the fetal-maternal conflict. This bioethical situation encapsulates factors from many different areas of study. The patient care of this mother must be considered with legalities, ethical considerations, religion, and gestational progression of the fetus. In this situation, the care team acts as a third-party source fighting to protect the interests of the fetus. This protection is essential as the fetus is an innocent being

without any power to protect itself. The fetus is completely reliant on its mother for its health and wellbeing. The care team recognizes the mother's responsibility to her fetus. Whilst the mother and the care team appear to be at odds, both groups are progressing with the same goal. Although their perspectives and path to do so differ, both mother and physician have the goal of delivering a healthy baby.

The fetal-maternal conflict describes a medical situation where the well-being of the mother and fetus must be acknowledged. Most people would agree that a mother has a direct responsibility to ensure the health of her baby. A fetus stands at equal importance to the mother when she plans to bring her pregnancy to term. A mother must acknowledge that she forfeits certain privacy and autonomy when she holds another individual with rights and the possibility of life in her womb. It becomes easy to scrutinize mothers for the decisions they make, which ultimately negatively impact their fetus. However, the analysis of this conflict reveals that the majority of mothers do not wish to intentionally damage their babies. These women act based on their current knowledge, fear, and cultural and religious beliefs. The interdisciplinarity of the fetal-maternal conflict must be acknowledged to effectively combat conflict and protect the interests of the nation's children.

References:

Denny, L., Coles, S., & Blitz, R. (2017). Fetal Alcohol Syndrome and Fetal Alcohol Spectrum Disorders. *American family physician*, *96*(8), 515–522.

Deshpande, N. A., & Oxford, C. M. (2012). Management of pregnant patients who refuse medically indicated cesarean delivery. *Reviews in obstetrics & gynecology*, *5*(3-4), e144–e150.https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3594862/pdf/RIOG005003_e144df

Flagler, E., Baylis, F., & Rodgers, S. (1997). Bioethics for clinicians: 12. Ethical dilemmas that arise in the care of pregnant women: rethinking "maternal-fetal conflicts". *CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne*, *156*(12), 1729–1732. https://www.cmaj.ca/content/cmaj/156/12/1729.full.pdf

Goldenring J. M. (1985). The brain-life theory: towards a consistent biological definition of humanness. *Journal of medical ethics*, *11*(4), 198–204. https://doi.org/10.1136/jme.11.4.198

Linda Farber Post, *Bioethical Consideration of Maternal-Fetal Issues,* 24 Fordham Urb. L.J. 757 (1997). https://ir.lawnet.fordham.edu/ulj/vol24/iss4/10

Ludwig, M.J. *Maternal / fetal conflict*. Maternal / Fetal Conflict | UW Department of Bioethics & Humanities. (n.d.). Retrieved April 3, 2022, from https://depts.washington.edu/bhdept/ethics-medicine/bioethics-topics/detail/69

Schenker J. G. (2008). The beginning of human life : status of embryo. Perspectives in Halakha (Jewish Religious Law). *Journal of assisted reproduction and genetics*, *25*(6), 271–276. https://doi.org/10.1007/s10815-008-9221-6

*When human life begins*. American College of Pediatricians. (n.d.). Retrieved April 3, 2022, from https://acpeds.org/position-statements/when-human-life-begins