Ethical issues arising in relation to consent in pregnancy and maternity care

22 October 2020, Dr. Joan McCarthy
School of Nursing and Midwifery, UCC
j.mccarthy@ucc.ie

A TRADITION OF INDEPENDENT THINKING

UCC
University College Cork, Ireland
Coláiste na hOllscoile Corcaigh

Indispensable reproductive work

Carrying a pregnancy, and undertaking labour, childbirth and postnatal care is indispensable work that makes a profound and significant contribution to human life and human community.

It

- requires continuous self-management and self-regulation.
- impacts on the physiological, psychological, social, emotional health and well-being of the pregnant woman as well as on the health and well-being of the foetus.
- gives rise to ethical challenges because fundamental rights and interests come into conflict and ethical values are at risk including:
    - Bodily integrity, inviolability and autonomy
    - Health, well-being, human life
    - Justice

The relationship between woman and foetus

The way the relationship between the pregnant woman and the foetus is framed or understood

is crucial to the way in which the pregnant woman is treated in law, policy and clinical practice.

But how it is framed is **complex and contested**

Is the relationship one between

a) separate entities where the foetus and the woman are distinct? Leads to emphasis on foetal rights.

b) part and whole where the foetus is viewed as part of the woman's body? Leads to emphasis on woman's rights.

c) ‘not one, but not two’ (Halliday 2016: 182/Karpin 1992)

Emphasis on the unique interconnection and interdependence of the pregnant woman and the foetus:

“[T]he fetus is not simply an entity extrinsic to her which happens to be developing inside her body... It is a being, both inseparable and yet separate from her, both part and soon to be independent from her.”
(Mackenzie 1992: 148)

Leads to emphasis **on women’s rights** and **responsibilities**

Ireland pre and post 8th Amendment, May 2018

- Pre-2018, the foetus from its earliest stage had the same legal standing as the pregnant woman (a).
- Led to chilling and tragic examples of efforts and decisions made by the HSE and Irish courts to compel pregnant women to undergo medical interventions or forego medical treatment in the interests of the foetus.
- Post-2018, an evolving legal, social and political consensus is that the foetus has moral and legal standing but that it does not have the same rights as persons (c).

HSE National Consent Policy 2019: information

Service users who are pregnant **must have received sufficient information** in a manner that is comprehensible to them about the nature, purpose, benefits and risks of an intervention or lack thereof **on their health and life.**
…**will need to receive sufficient information** about the benefits and risks of an intervention or lack thereof on the **viability and health of a foetus**
…**will also need sufficient information** on the benefits and risks of an intervention or failure to intervene **on the viability and health of the child that will be delivered.**
(p.28-29)

In short, the Consent Policy holds health professionals to the same standard of information provision for pregnant women as it does for non-pregnant people while recognizing that the woman's decision impacts on foetal life.

HSE National Consent Policy 2019: consent

- makes it clear that health professionals are required to **secure the consent** of the pregnant woman for any medical intervention up until the birth of the baby.

- The obligation to respect autonomy in the policy equally applies to pregnant women. Health professionals need:
  "to respect the service user's right to **self-determination (or autonomy)** – their **right to control their own life and to decide what happens to their own body…**
  [the service user has] ultimate **decision-making authority** … [and] **are the experts** in determining what 'ends' matter to them…[including] how they should live their everyday lives …. decisions about risk-taking and preference for privacy or non-interference" (pp.20-21)

- It also specifies that treating competent service users, including pregnant women, without their consent is a violation of their legal and constitutional rights.

Tensions: refusal of treatment

Yet, internationally, while policies and laws recognize the rights of pregnant people are on a par with non-pregnant people, **in practice,** this may be undermined.

- Refusals of clinically indicated treatment often prompt questions about the woman's capacity.
- Conflicts can be exacerbated by advances in medical technology which enable the foetus to become visible as well accessible through, for example, *in vivo* diagnostic and surgical interventions. Technologies such as ultrasound scans (though often welcome) visually disconnect the foetus from the pregnant woman suggesting it is free-floating and separate from her.
- These technologies can also reinforce medical authority and scrutiny and diminish the woman's knowledge, trust in her own experience, and her commitment to do everything in her power to ensure the best possible start in life for her child. (McLean 2009: 131)

The National Care Experience Programme (2020) Findings of the National Maternity Experience Survey 2020 p.66 and p.17. Available to download at: https://yourexperience.ie/maternity/about-the-survey/

Tensions: context of decision-making

In everyday situations, how easily can women dispute what doctors and midwives ask of them?
The **context of decision-making** is significant.

In the clinic, there is an asymmetry of authority and control between the health professional and the pregnant woman – whatever authority she may have or lack in other contexts. (Kukla 2009: 47)

In addition, structural factors such as class, race, gender, and ability shape and constrain the decision-making process in different ways such as lending credibility to some voices while filtering out or discrediting others.

These asymmetries suggest that a woman's consent to treatment may resemble acquiescence more closely than actual agreement and ownership of the decision.

To conclude

Reciprocity on the part of the state and society in general for the indispensable reproductive work of pregnancy and maternity sets a high bar for the quality of services and supports that should be put in place.

Obliges health professionals and organisations to ensure that these services:

- are genuinely **woman-centred** and **inclusive**
- involve **shared decision-making** where both women and professionals are **recognized as experts** and asymmetries of power and authority between them are reduced

(Begley et al 2019)

- offer **meaningful and realizable options** regarding who assists women, where and how
- include **advance planning** to build trust and cooperation as well as anticipate conflict and avoid it

Received: 15 February 2019 | Revised: 26 May 2019 | Accepted: 5 July 2019

DOI: 10.1111/jep.13243

ORIGINAL PAPER

WILEY Journal of Evaluation in Clinical Practice
International Journal of Public Health Policy and Health Services Research

Shared decision-making in maternity care: Acknowledging and overcoming epistemic defeaters

Keith Begley PhD[1] | Deirdre Daly PhD[2] | Sunita Panda MSc[2] | Cecily Begley PhD[2]

[1] Department of Philosophy, Trinity College Dublin, Dublin, Ireland

[2] School of Nursing and Midwifery, Trinity College Dublin, Dublin, Ireland

Correspondence
Keith Begley, Department of Philosophy, Trinity College Dublin, College Green, Dublin, Ireland.
Email: begleyk@tcd.ie

Funding information
Health Research Board, Ireland, Grant/Award Number: HPF-2016-1671

Abstract

Shared decision-making involves health professionals and patients/clients working together to achieve true person-centred health care. However, this goal is infrequently realized, and most barriers are unknown. Discussion between philosophers, clinicians, and researchers can assist in confronting the epistemic and moral basis of health care, with benefits to all. The aim of this paper is to describe what shared decision-making is, discuss its necessary conditions, and develop a definition that can be used in practice to support excellence in maternity care. Discussion between the authors, with backgrounds in philosophy, clinical maternity care, health care management, and maternity care research, assisted the team to confront established norms in maternity care and challenge the epistemic and moral basis of decision-making for

References

Goodwin M (2017) How the Criminalization of Pregnancy Robs Women of Reproductive Autonomy. IN *Just Reproduction: Reimagining Autonomy in Reproductive Medicine, Special Report, Hastings Center Report* 47(6): S19-S27.

HSE (2019) National Consent Policy. Available to download at: https://www.hse.ie/eng/about/who/qid/other-quality-improvement-programmes/consent/national-consent-policy-hse-v1-3-june-2019.pdf

Karpin I (1992) Legislating the Female Body: Reproductive Technology and the Reconstructed Woman. *Columbia Journal of Gender and Law.* 325: 329.

Johnston J, Zacharias RL (2017) The Future of Reproductive Autonomy. IN *Just Reproduction: Reimagining Autonomy in Reproductive Medicine, Special Report, Hastings Center Report* 47(6): S6-S11.

Halliday S (2016) *Autonomy and Pregnancy*. Abingdon Oxon: Routledge.

Kukla R (2009) Communicating Consent. *Hastings Center Report*, May-June 2009: 45-47.

Mackenzie C (1992) Abortion and embodiment, *Australasian Journal of Philosophy* 70(2):136-155

Morgan LM (2011) Fetal bodies, undone. IN *A Companion to the Anthropology of the Body and Embodiment.* Frances E. Mascia-Lees, ed., pp. 320-337. Malden, MA: Wiley-Blackwell.

McLean S (2009) Autonomy and Pregnancy, Chp 5 IN Autonomy, Consent and the Law. Taylor & Francis Group, pp.128-154.