Best Practice & Research Clinical Obstetrics and Gynaecology 43 (2017) 10–20

Contents lists available at ScienceDirect

Best Practice & Research Clinical Obstetrics and Gynaecology

journal homepage: www.elsevier.com/locate/bpobgyn

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Maternal Decision-making During Pregnancy: Parental Obligations and Cultural Differences

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Keywords:
pregnancy
decision-making
parental obligations
counseling
cultural differences

Decision-making during pregnancy can be ethically complex. This paper offers a framework for maternal decision-making and clinical counseling that can be used to approach such decisions in a systematic way. Three fundamental questions are addressed: (1) Who should make decisions? (2) How should decisions be made? and (3) What is the role of the clinician? The proposed framework emphasizes the decisional authority of the pregnant woman. It draws ethical support from the concept of a good parent and the requirements of parental obligations. It also describes appropriate counseling methods for clinicians in light of those parental obligations. Finally, the paper addresses how cultural differences may shape the framework's guidance of maternal decision-making during pregnancy.

Introduction

Pregnant women today face an array of decisions during pregnancy. Better understanding of embryonic and fetal development has offered insight into the effects of choices about nutrition, medications, and other substance use. Genomic and genetic innovation and improved imaging allow prenatal diagnosis that can be used to inform decisions about pregnancy termination or appropriate intervention. Fetal therapy is now an option for a variety of conditions that previously entailed certain morbidity and mortality. Finally, fetal monitoring and new surgical delivery options are changing the

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http://dx.doi.org/10.1016/j.bpobgyn.2017.02.002
1521-6934/

way pregnant women prepare for birth. This list excludes related questions about how and when to conceive and any medical intervention that might be appropriate after a baby is born.

New knowledge and technology hold great potential to improve the well-being of both women and fetuses and create new options that can raise challenging questions about whether, when, and how to employ such knowledge and technology. Therefore, pregnant women and their health care providers face an expanding set of decisions as a routine part of prenatal care when pregnancy progresses normally and an even more complex array of options when concerns arise. In this review, questions of who should make decisions during pregnancy and how those decisions should be made are explored. The role that a clinician should play in these decisions and ethical justifications for various counseling approaches are described. Finally, strategies for negotiating cultural differences are presented.

It is worth clarifying from the outset that the vast majority of these decisions are not governed by legislation in most countries (with some notable exceptions such as elective pregnancy termination). In contrast, many of the world's religions do offer direct or indirect guidance about what a woman should or should not do during pregnancy. Religious beliefs and perspectives are therefore likely to have a considerable impact on the decision-making processes of some pregnant women. Although law and religion may inform or influence these decisions, the focus of this review is not on legal or religious considerations but on the *ethical* aspects of decision-making during pregnancy.

A Case to Consider

> Mrs. S is 31 years old and 20 weeks into her first pregnancy. During the routine anatomy scan performed at 19 weeks, a thoracic myelomeningocele was found. Mrs. S was referred to a nearby fetal therapy center for further evaluation where MRI confirmed the ultrasound finding and revealed a Chiari II malformation of the brain. No other congenital anomalies were identified, and the baby's karyotype was normal. Dr. Y explained the condition to Mr. and Mrs. S and described two different treatment approaches: fetal surgery or postnatal repair. Although postnatal repair is the standard of care, limited available research has shown improved outcomes for children undergoing *in utero* surgical repair. Fetal surgery, however, involves risk to the fetus and to the pregnant woman associated with both the surgery itself and future pregnancies.
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> Mrs. S has decided that she wants to undergo the surgery to minimize the effects of the neural tube defect for her child. Mr. S, however, is strongly opposed. He does not believe that the available evidence of benefit to the child is sufficient to justify the risks to Mrs. S and the future children they hope to have. Dr. Y wonders how to proceed further.

Dr. Y's initial efforts should focus on answering questions and correcting any misunderstanding Mr. and Mrs. S may have. Once this has been accomplished, a number of ethical questions arise: Is the informed permission of both parents required for decisions that impact a fetus? Who is entitled to make this choice? What ethical considerations should guide the decision-making process? What is the appropriate role of the physician in that process?

Who should make decisions?

In Western society, we have a well-established ethical consensus that treatment decisions during pregnancy are left solely to the pregnant woman. A woman's right to determine what happens to her own body has such great moral weight that it overwhelms all other ethical considerations that might come into play. This position is built upon the bedrock of medical ethics: the requirement to obtain the informed consent of a patient undergoing medical intervention [1]. It is buttressed by considerations of justice, gaining support from the view that pregnant women are entitled to the same rights that other women are entitled to, including the right to make decisions affecting their bodily integrity [2]. Conflicting ethical norms including the interests of an intimate partner, the well-being of the fetus, and even the well-being of the pregnant woman are insufficient to upend the priority of maternal autonomy.

Professional organizations have explicitly embraced this view in statements regarding fetal intervention and other types of decisions during pregnancy. The American College of Obstetricians and Gynecologists states, "although it may be appropriate and helpful for the father to be involved in these decisions…to assign him any authority to assent or dissent would unjustifiably erode the autonomous decision-making capacity of the pregnant woman" [3]. This position leaves little ambiguity about the question of whose wishes should Dr. Y follow and whether the informed permission of Mr. S is necessary to perform fetal surgery in this case.

Perhaps because of the widespread agreement about a pregnant woman's decision-making authority, only minimal consideration has been given to the role of the intimate partner in such scenarios. Guidance about incorporating the beliefs and preferences of the father of a fetus is nearly nonexistent. Limited commentary on involving the partner in decision-making about fetal surgery focuses on the threats that it poses to the pregnant woman's autonomy [4]. The few papers that have taken the father's perspective seriously concern the most extreme maternal decision: the elective abortion of a fetus. Hardwig has eloquently argued that the father's perspective ought to be taken into account by the pregnant woman and that in some cases, she may be obligated to terminate a pregnancy that she wants to carry to term on the basis of his desire to avoid fatherhood. It is worth noting that Harris is making an ethical claim as opposed to a legal one, explicitly stating that he would not support the legal enforcement of this approach [5]. Therefore, there is much work to be done to better understand the optimal role for men like Mr. S in decision-making during pregnancy.

It is worth noting that this analysis does not rely on the particular medical details of the case described above. The ethical analysis would be similar in any case involving a pregnant woman with a dissenting partner. For example, the same conclusion might be drawn about a case in which the woman chooses to smoke, agrees to recommended chemotherapy, decides to discontinue antidepressants, or refuses cesarean section. The nature and extent of harms and benefits to both her and the fetus do not affect the answer to the question of who is the ethically appropriate decision-maker in situations involving a capacitated pregnant woman.

The single exception to the consensus that decision-making during pregnancy is the sole prerogative of the pregnant woman arises in the context of research. The Common Rule (45 CFR 46) [6], which governs research at institutions that accept federal funding, requires institutional review boards to only approve research protocols in which the consent of the father of the fetus is required for the pregnant woman and fetus to participate in any research protocol intended only for fetal benefit (45 CFR 46.204). The American College of Obstetricians and Gynecologists, however, has criticized this regulation, stating that requiring an intimate partner's consent is not ethically justified [7].

How should decisions be made?

Having clarity about *who* is the appropriate decision-maker does not offer much insight into *how* decisions should be made during pregnancy. What ethical considerations should Mrs. S take into account when she is choosing a treatment approach? What ethical constructs should she use to shape and guide her deliberations?

Two Flawed Approaches

In light of the conclusions of the previous section, it might be tempting to assume that a pregnant woman's interests should routinely be given first priority when making decisions during pregnancy. The singular focus on a pregnant woman's decisional rights and arguments about the importance of equal treatment of pregnant women might make this type of hierarchical model seem plausible. Such an approach would first maximize benefits and minimize burdens to the pregnant woman and only take the well-being of the fetus into account as a secondary consideration. An intervention such as fetal surgery to correct a neural tube defect would only be permissible if the risks and burdens for the pregnant woman were minimal.

However, this woman-centered approach would be problematic for at least two reasons. First, although it is true that the fetus does not have the ability or the legal right to participate in decision-making during pregnancy, it does have interests that may be dramatically affected by the decision [8].

Routinely marginalizing those interests in favor of maternal well-being would disregard the morally relevant consequences of those choices for a future child. Second, this approach would run counter to the instinct of many (if not most) pregnant women to prioritize the well-being of their fetus and accept significant risk to promote it. As a result, a model that routinely prioritizes the interests of a pregnant woman would be both theoretically and pragmatically inappropriate.

A second existing framework that may offer insight into decision-making during pregnancy can be found in pediatric ethics. If a pregnant woman has indicated that she considers her fetus to be a future child and wants it to be treated as such by the medical team, the fetus gains the status of patient [9]. The Best-Interest Standard has stood for years as the guiding principle for parents (and clinicians) making decisions on behalf of their minor children (and patients) [10]. Such an approach would prioritize the well-being of the future child, permitting and possibly requiring intervention for fetal benefit even when risks and burdens for the pregnant woman are significant. It would imply that Mrs. S is morally obligated to undergo the surgery to promote fetal interests.

The Best Interest Standard has been criticized on a number of different grounds. Scholars have argued that it is vague, overly aspirational, culturally insensitive, and blind to contextual considerations [11,12]. These are important critiques, but the more central reason for the Best Interest Standard being an inappropriate framework for guiding decision-making during pregnancy is that it is not designed to take into account the consequences of the decisions for the pregnant woman. By definition, a fetus is a living being that exists within another living being. Any plausible moral approach to decision-making during pregnancy must therefore incorporate consideration of that being, making the pediatric Best Interest Standard inadequate for this purpose.

The failure of these two approaches makes it clear that routinely prioritizing either maternal or fetal interests when making decisions during pregnancy would be problematic. Even so, each of these approaches captures something ethically significant, indicating a need for a framework that recognizes both the interests of the pregnant woman and the interests of the fetus, integrating these considerations when interests are not aligned. With regard to the case described above, a defensible ethical approach would seriously consider both the impact on the couple's future child and the effect on Mrs. S.

An Alternative: Parental Obligations

For many years, challenges of this type were referred to as "maternal-fetal conflicts." Under this paradigm, pregnant women and clinicians were tasked with finding the ethically appropriate trade-off between maternal and fetal interests. The implication was that this type of situation was a zero-sum game in which the promotion of the well-being of one party necessitates compromising the well-being of the other. More recent work, however, has criticized this description, proposing the reconceptualization of such situations [13]. Rather than assuming a conflict-based approach to these questions, proponents of this alternative view emphasize the interrelatedness of a pregnant woman and her fetus. They point to the difficulty of sensibly separating the well-being of a pregnant woman and her fetus, given fetal dependency on the woman and many women's desire to do what is best for their future children.

Specific description of how this revised paradigm should inform and guide maternal decision-making has been limited. One approach that has been proposed is grounded in the relationship between the pregnant woman and the fetus—that of a parent and (future) child [14]. This approach uses as its guiding question, "What would a good parent do?" It takes seriously the interrelatedness of the interests of the pregnant woman and fetus while offering a specific framework for understanding the nature of that connection. Pregnant women planning to have a child take on the responsibilities associated with becoming a parent and therefore should seek to make decisions during pregnancy that are consistent with those required by parental obligations. It is worth emphasizing that this relationship is only established in cases in which the pregnant woman decides to carry a fetus to term and so does not preclude termination of pregnancy as an ethically acceptable option.

This approach, of course, relies heavily on the concept of parental obligations, which have not been clearly and uniformly defined. A plausible definition would require a parent to protect the interests of her child to a minimal degree and promote the interests of that child when it is feasible for her to do so at reasonable cost [14]. It establishes a baseline of well-being below which parents should not allow

their children to fall (if possible) and a method for integrating the interests of parents and children when above that baseline. Therefore, parental obligations require that parents place importance on the well-being of their children. They also incorporate the expectation that a good parent will, under some circumstances and to some degree, sacrifice her own interests to promote the interests of her child.

This expectation, however, has limits. When the burdens or costs of promoting a child's interests become unreasonable in relation to the benefit expected for the child, the parent is not ethically obligated to take those actions. Understanding what constitutes "reasonable cost" is clearly key to the application of this framework: parents may disagree about what costs or burdens would be reasonable to bear to bring about some particular benefit. Even so, this framework offers some specific guidance for maternal decision-making. When applied to the case of Mrs. S, the lens of parental obligations offers insight into how she should make the decision about whether to pursue fetal surgery to correct her fetus's neural tube defect *in utero*.

Would the intervention under consideration protect the interests of the child to a minimally acceptable degree? If so, there would be a strong argument for doing so under the paradigm of parental obligations. In this case, however, fetal surgery is an innovative procedure, with only limited evidence about its effectiveness. Because the extent of potential benefit has not been clearly established, it is not known whether the intervention will make a difference to ensure that the child's interests are protected to the requisite minimal degree. Further, the likelihood of benefit of any amount is empirically uncertain. In other words, it is not known whether or how likely it is that the intervention will make it possible for Mrs. S's future child to avoid significant physical and mental impairments that would cause him or her to fall below a minimally acceptable level of well-being. It therefore seems that this parental obligation would not require Mrs. S to decide to undergo fetal intervention in this case.

What about the second part of the parental obligation: to promote a child's interests when one can do so at reasonable cost? Some of the same considerations are relevant in the analysis of this question. Because of the intervention's limited evidence and uncertainty about the degree of benefit, its costs or burdens would have to be relatively low to be judged as reasonable. However, as described in the case, the risks of the surgical approach used are significant for the pregnant woman, the fetus, and future pregnancies. As a result, it would be difficult to find sufficient ethical support the position that a pregnant woman has a parental obligation to undergo surgery in this case.

Morally Relevant Variables

This conclusion, however, may not apply to all cases of fetal surgery for myelomeningocele. The analysis of this decision would change depending on the facts of the particular case at hand. A number of variables are relevant, including the severity of the condition, the likelihood and extent of possible benefit, the evidence available, and the level of risk involved.

Consider a similar case in which the lesion is a sacral meningocele rather than the more severe lesion described above. The child's prognosis would be significantly better in such a case, above the minimal threshold of well-being a parent is required to protect (assuming no other congenital problems have been identified). The surgery would then be an opportunity to promote the child's interests beyond this minimal level. Mrs. S would only have a parental obligation to choose the surgery if the cost or burden to her would be reasonable.

Another variation of the case would be one in which the expected benefit associated with the surgery has been empirically demonstrated to be high. The greater the anticipated benefit and the more likely that benefit is to come about, the stronger the argument for a parental obligation to choose that option. Similarly, the level of evidence available is an important variable to take into account: when potential benefits of intervention are highly speculative, the ethical justification for choosing that intervention is less robust. As a result, a parent can only be ethically obligated to choose intervention if (1) there is solid evidence that the benefit of that intervention is likely to be sufficiently great that the well-being of the fetus will be protected to the requisite minimal degree or (2) the burdens or costs of the intervention are reasonable in relation to the anticipated benefits, adjusted for likelihood and level of evidence. If the benefits of surgery have been shown to be likely and significant, Mrs. S may have a parental obligation to accept some cost or burden to herself to protect her future child's interests to a minimal degree or to promote those interests.

A third ethically relevant variable that might change the analysis of this case is the extent of the costs or burdens to the pregnant woman. As the case was described, fetal surgery involves significant risk to both the pregnant woman and future fetuses. However, less invasive techniques for fetal surgery are under development, and at some point, the risks associated with this intervention could become minimal. If the risks are small, interventions with minor anticipated benefits may be required by parental obligations. In other words, Mrs. S may have an ethical obligation to choose to undergo a surgery that is expected to have moderate benefits for the fetus if the costs and burdens of undergoing surgery are minimal for Mrs. S.

To summarize, the severity of the underlying condition; the likelihood, degree, and evidence base of the anticipated benefits; and the extent of the costs and burdens involved all must be considered when evaluating whether a pregnant woman has a parental obligation to make a particular choice. If the proposed fetal surgery is known to have high expected benefits for a fetus such that it protects the future child's interests to a minimally acceptable degree or promotes it at minimal risk to the pregnant woman, there is strong justification to support the claim that Mrs. S is ethically obligated to choose that approach. In circumstances where the facts are different, different conclusions are likely to be drawn. Systematic consideration of these morally significant variables can offer guidance about the existence of a parental obligation in any particular case and therefore constitute a framework with which pregnant women can make difficult choices.

What is the role of the clinician?

In the case of Mr. and Mrs. S, it is clear that Mrs. S is the individual who should be making decisions. A framework based on parental obligations that considers a number of variables can help guide her decision-making. The narrow focus on the pregnant woman may raise questions about the role of the clinician in the decision-making process, but clinicians' input and guidance are vital to maternal decision-making during pregnancy.

Identifying the Decision-maker

Physicians are in position to clarify who should make decisions that need to be made during pregnancy. This can be done implicitly in most situations by directing conversation to and soliciting the perspective of the pregnant woman. In other cases, particularly those involving disagreements among present parties or those in which the pregnant woman seems unduly influenced by the opinions of those around her, the issue may need to be addressed more explicitly. Finding an opportunity to speak with the woman alone, trying to understand her situation, and reassuring her that it is her decision to make may help clarify her authority and resolve conflicts.

This approach does not require that a clinician exclude others from involvement in decision-making during pregnancy. Many pregnant women desire and seek the inclusion of their intimate partner, family members, or friends in this process. Clinicians should include these other individuals to the degree permitted by the pregnant woman. If questions arise, they should approach the woman directly and ask how she would like others to be involved.

Explaining Alternatives

A second crucial role of physicians with regard to maternal decision-making is the determination of the clinical picture and the identification and explanation of medically reasonable options. Informed consent is not possible without a thorough understanding of the diagnosis, prognosis, and treatment alternatives [1]. Equally important for the framework proposed, these details are necessary for the assessment of whether a pregnant woman has a parental obligation to choose one approach over others. Description of treatment options should therefore include the morally relevant variables identified in the previous section: the current and future condition of the pregnant woman and fetus, the extent and likelihood of anticipated benefits, the quality of evidence available, and the costs and burdens associated with intervention. Specificity to the extent possible and appropriate for the particular woman should be offered.

Participating in Shared Decision-making

Beyond clarifying who is the decision-maker and offering information about the current situation and possible treatment options, it is the role of the clinician to counsel the pregnant woman about her decision. The process of shared decision-making requires more than simply explaining the alternatives: it involves engaging in a dialogue in which the clinician and patient jointly consider the alternatives in light of the patient's values and preferences [15,16]. A clinician may approach this dialogue differently in different situations. In some cases, a nondirective approach may be appropriate while giving a clear recommendation or even persuasion could be ethically justifiable in others [8,9]. Consideration of the pregnant woman's obligations can offer a framework to guide the clinician in choosing the best approach in any given case.

If a pregnant woman clearly has a parental obligation to choose one available option, a clinician should take a directive approach to counseling. The degree of directiveness the clinician should use is positively correlated to the strength of the parental obligation. So in a case in which a well-researched intervention is highly likely to bring about significant benefit for a future child with minimal burden for the pregnant woman, a directive counseling approach would be ethically appropriate. The clinician should state a recommendation and perhaps attempt to persuade (but not manipulate or coerce) the pregnant woman to choose that treatment approach. Agreeing to a cesarean section recommended for fetal indications and complying with a management plan for severe gestational diabetes are examples of such scenarios.

In contrast, there are some cases in which a proposed intervention clearly falls outside the requirements of parental obligations. When the potential benefits are uncertain or marginal and the risks are substantial, a pregnant woman is not ethically required to choose that intervention, although she may be willing and even eager to do so. In cases that fit this fact pattern, the clinician's approach to shared decision-making should be nondirective. It should focus on eliciting the values and preferences of the pregnant woman and selecting a course of action that most closely aligns with them. If a recommendation is offered, the clinician should make it clear to the pregnant woman that other approaches are also acceptable to avoid having undue influence on the woman's decision-making. A situation that would fall under this category could be one in which a woman decides to go off of her selective serotonin reuptake inhibitor upon finding out she is pregnant.

Finally, clinicians may encounter cases in which a pregnant woman requests an intervention that would conflict with her parental obligations. Such cases are rare but do occur. For instance, consider a situation in which a woman wants her child to be born on a particular day for spiritual or sentimental reasons and asks her obstetrician to induce labor at 36 weeks. How should the obstetrician respond? Despite the ethical value of respecting the pregnant woman's wishes, the obstetrician is not obligated to do so under these circumstances. Ethical support for refusing such a request is *not* grounded in consideration of the pregnant woman's parental obligations—the clinician's role with regard to those obligations is entirely advisory. The clinician's duty to respect the pregnant woman's autonomy would preclude *enforcing* the fulfillment of her parental obligations against her wishes. Instead, refusal is ethically grounded in his own professional obligations. If the pregnant woman makes a request that harms the fetal patient without sufficient potential benefit to justify that harm, the clinician's fundamental duty to act in accordance with professional standards would likely conflict with that request and require that he decline.

Of course, there are some cases in which the facts do not align with one of these clear-cut patterns. It may be difficult to evaluate whether a pregnant woman has a parental obligation to make a particular choice when both the risks and the benefits are very great or very small. Further, because of the paucity of research conducted on pregnant women, there are likely many situations in which the evidence base supporting one approach or another is not robust. In such cases, a clinician's approach to shared decision-making should be directive to a degree proportional to the strength of the parental obligation. A nondirective or minimally directive approach will therefore be appropriate in most cases that fall within these gray areas.

It should be re-emphasized that this framework only applies in situations where the pregnant woman has made it clear that she intends to carry her pregnancy to term. If she has decided to terminate her pregnancy, she does not have parental obligations regarding that future child, and therefore, the clinician's primary consideration should be the wishes and well-being of the pregnant woman.

Returning to the case of Mr. and Mrs. S, the ethical approach for Dr. Y is now more clear. He should first clarify who is the decision-maker. Given that there is a disagreement between Mr. and Mrs. S about the treatment plan, it would be appropriate to talk with Mrs. S alone to establish that it is her decision to make and ask how she would like Mr. S to be involved. Second, Dr. Y should confirm that Mrs. S understands the relevant information about her alternatives, their risks, potential benefits, and the level of evidence available to support them. Finally, given the innovative nature of fetal surgery and the significant risk to Mrs. S, he should engage in the process of shared decision-making in a nondirective way. This approach involves soliciting her values and preferences and explaining how each alternative aligns or conflicts with them. Although this process may be time-consuming, it ensures that the clinician resolves this challenging case in an ethically appropriate way.

Cultural Differences

Thus far, we have looked at maternal decision-making through the lens of Western perspectives and values. We have relied on concepts of autonomy, parenthood, and well-being that are central to our culture but are not universally defined and shared. Reviewing the wide array of existing cultural beliefs that might impact decision-making in the context of pregnancy is beyond the scope of this paper. Even so, it is possible to consider how a clinician should respond to decisions that reflect the perspectives and values of cultures other than our own. Medical practice in the Western world has been shaped by a particular set of ethical norms; how should clinicians provide care to patients whose ethical norms are different? Should patient preferences or provider paradigms take precedence?

Ethical questions surrounding reproduction are some of the most challenging questions encountered in clinical practice, even *within* a Western context. It is therefore not surprising that there are many assumptions in the preceding arguments that are likely to be rejected by different cultures around the world. Some of the most significant areas of difference include women's role in decision-making, the obligations that parents have to their children, the value of life, perspectives on disability, and the interaction between clinicians and patients.

The need for clinicians to demonstrate sensitivity to cultural differences has received increasing attention in recent years. Scholars have discussed the importance of such awareness for providing excellent patient care [17] and have identified knowledge, skills, and attitudes clinicians can use to achieve this goal [18]. It has been argued that cultural competence is in line with other ethical obligations [19]. Further, the United States' accrediting bodies require cultural competency to be covered in both undergraduate and graduate medical education [20,21].

Although it is clear that sensitivity to and respect for other cultures' norms and practices should be among the core commitments of clinicians, it is less obvious what, specifically, those commitments require and how far they extend. Acknowledging and exploring a patient's cultural perspective may be ethically required, although blind deference to that perspective is not. Clinicians may accommodate some culturally driven decisions but resist others. This final section offers guidance about how to approach interactions with patients from cultures with different sets of ethical premises shaping their views on decision-making during pregnancy.

Who should make decisions?

The moral and legal right of a woman to make decisions about her own body (whether or not she is pregnant) is not unique to Western culture, but it is also not universally accepted. In some parts of the world, women are possessions of their families or spouses and are required to act in accordance with their direction. Less extreme patriarchal cultures do not consider women to be property but nonetheless expect them to follow the instructions of their fathers or husbands. Pregnant women coming from a culture that places less value on women's autonomy may have a different set of expectations about how decisions should be made during pregnancy. As a result, clinicians may be uncertain how to proceed when caring for patients from such cultures.

The fact that a pregnant woman has a well-established right to make autonomous decisions does not entail that she is *required* to do so. She may choose to waive that right and request that another individual make decisions. Alternatively, she may choose to retain decision-making authority but to

effectively cede that prerogative to another person by making whatever decision that person recommends. Therefore, a pregnant woman's right to make autonomous decisions includes the right to choose how the decision will be made and by whom.

Cultural differences with regard to who should make decisions during pregnancy can therefore be accommodated in many cases by offering the pregnant woman the opportunity to clarify how she would like others to be involved in the decision-making process. It is particularly important that this type of conversation be conducted with the pregnant woman alone in the hope of soliciting her own authentic perspective. Emphasizing the professional obligation to maintain confidentiality may also help achieve this objective. With a clear picture of how the pregnant woman wants decisions to be made, the clinician can coherently fulfill his obligation to respect the woman's decision-making authority while accommodating cultural differences.

How should decisions be made?

The guiding concept that a pregnant woman intending to bring a pregnancy to term should make decisions in accordance with parental obligations is not specific to a Western world view. Even so, the specific ethical guidance offered by this framework may vary dramatically from culture to culture. The relationship between parents and their children has changed over time and differs throughout the world. Today's Western perspective views children as cherished miracles to be loved unconditionally, protected from harm, and supported to achieve their highest potential. In other times and places, however, children have primarily played other roles such as agricultural workers, bearers of family names and reputations, and caregivers for aging parents. This observation suggests that parental obligations are, at least to some degree, relative to the context in which the parents live. As a result, a framework built on those obligations may provide different guidance in different contexts.

More fundamentally, parental obligations may reflect other values of the culture to which the parents belong. There are dramatic differences in whether and how individuals attribute moral status to a fetus and even future children. If a pregnant woman does not view her fetus as having moral status, she may not believe that she has parental obligations to it. Similarly, variations in how cultures understand, accept, and accommodate disability may affect the pregnant woman's perception of her duties to protect and promote the future child's well-being. Further, the minimally acceptable level of well-being that a parent is expected to protect may change from context to context, and the threshold for what is a "reasonable" burden to bear for promoting the future child's interest may vary. These cultural differences lead to different understandings of what choices would fall under the umbrella of parental obligations.

This is not to say, however, that any decision can be considered to be in line with what a good parent would do. Although there may be some disagreement about the appropriate role of a parent and about some fundamental assumptions that shape parental obligations, the latitude this disagreement allows has limits. The fact that a vulnerable person capable of pain and suffering is brought into being when a pregnant woman voluntarily has a child entails at least some minimal responsibility in any civilized culture for that woman to protect and promote that child's interests when possible. Although it is not possible to offer a defense of this claim here, it should be sufficiently plausible to show that cultural relativism does not undermine the framework proposed. Evaluating and describing the relevant variables and alternatives is therefore an important part of the clinician's role to facilitate maternal decision-making even in the face of significant cultural differences.

What is the role of the clinician?

The role of the clinician in identifying a decision-maker and facilitating maternal decision-making has been described in the two previous sections. But how should a clinician approach counseling a patient from a different culture? One central element of shared decision-making is soliciting and seeking to understand a patient's perspective. As a result, shared decision-making inherently involves appreciation for and accommodation of the pregnant woman's values and preferences. Culture-based norms and practices are therefore considered to at least some degree when a clinician's counseling efforts use this approach.

Beyond understanding a patient's cultural perspective, what are the ethical responsibilities of a clinician when counseling a pregnant patient? Our framework stipulates that a clinician is ethically justified in being directive when the pregnant woman has parental obligations to her fetus to choose one alternative over others. However, there may be reasons to take cultural differences into account when determining how directive a clinician should be when counseling a pregnant woman about treatment alternatives. If, on the basis of her own culture's norms, the pregnant woman does *not* have a parental obligation to choose the recommended option, a strongly directive approach (justified by the clinician's assessment that a parental obligation *does* exist) may be alienating. Disagreement about the existence of parental obligations likely indicates a fundamental difference between the values of the pregnant woman and the values of the clinician. In most cases, clinicians are cautioned against imposing their own values on their patients, suggesting that a less directive approach could be appropriate when cultural differences are involved.

Nonetheless, there are limits to a clinician's duty to accommodate a pregnant woman's preferences, even when they are derived from cultural norms. If a woman makes a decision that is not in line with any reasonable understanding of parental obligations, the clinician may be ethically justified in declining to implement that treatment approach. Although this type of refusal may have consequences for the clinician–patient relationship, those consequences may be acceptable to protect the clinician's professional integrity.

Pregnant women may face difficult decisions during pregnancy. The clinicians caring for them must be prepared to work with women to make these decisions in a consistent and ethically justified manner. Supporting women in making choices that are in line with parental obligations while remaining sensitive to cultural differences requires the willingness to understand and respect women's perspectives. Clinicians must also use their judgment to recognize cases in which accommodating a pregnant woman's choice would conflict with their professional obligations and seek out alternative, ethically acceptable resolutions.

Conflicts of Interest

None.

Practice Points

- Pregnant women have the authority to make decisions about interventions during pregnancy
- Decisions can be guided by reflection on parental obligations
- Directive counseling is an appropriate part of the process of shared decision-making in some cases
- The ethical justification for directive counseling may conflict with other ethical considerations when significant cultural differences are involved

Research Agenda

- The perspectives of women making difficult decisions in pregnancy
- The effect of directive counseling on outcomes for pregnant women and fetuses
- Specific strategies for working with pregnant women from various cultures

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