Fetal Spectrum Disorders: An Overview of Ethical and Legal Issues for Healthcare Providers

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Ethics are "the principles of conduct governing an individual or a group."[1] Ethical principles are involved when people attempt to explore and search for solutions regarding what is acceptable or unacceptable based on the norms of society. The study of ethics is integral for virtually every aspect of healthcare and fetal alcohol spectrum disorders (FASDs) are no exception. FASDs result from maternal alcohol use and are characterized by facial, growth, and central nervous system abnormalities. Discussions regarding the ethics of FASD include discussion of the four basic ethical principles: autonomy, beneficence, nonmaleficence, and justice,[2] as well as the issue of confidentiality. For this particular paper, the focus will be on the ethics surrounding prenatal alcohol use that could result in fetal alcohol spectrum disorders.

Since the four basic ethical principles (autonomy, beneficence, nonmaleficence, and justice) may conflict with one another in different situations that require healthcare decisions, clinicians must weigh each principle against the other three in each case. The principle of "autonomy" involves self-determination when making healthcare decisions. Adults are generally considered as being capable of such decisions, but persons with alcohol addiction or dependence (certainly minor children) may be considered to have limited capabilities in this regard.[3] For example, pregnant women are generally free to make autonomous decisions about their body but this may conflict with the principles of beneficence and nonmaleficence when the mother drinks alcohol during pregnancy, therefore exposing the fetus to its harmful effects. "Beneficence" is the principle that asks healthcare clinicians to seek the benefit of another, and to look out for his/her interest while "nonmaleficence" is the principle that seeks to "do no harm."[4] The principle of beneficence is exercised by healthcare clinicians when they promote the health of both the mother and the fetus and when they provide "skilled and compassionate care for persons born with an FASD."[3] Limiting the mother's access to alcohol would conflict with the principle of autonomy but would be in keeping with the principle of "nonmaleficence" toward the fetus. "Justice" refers to the fair, equitable, and appropriate treatment based on what is due to persons, and this is compromised when unfair rules and restrictions are imposed upon women who are pregnant.[3]

Beyond the four basic principles espoused by Beauchamp and Childress,[2] there is the principle of "confidentiality," which is also protected by state laws and statutes. But there are limits to confidentiality, such as when a pregnant woman reveals alcohol use that could endanger the life of the fetus. In this situation, the principle of confidentiality could conflict with the principle of nonmaleficence. From the legal standpoint, in 1998, Wisconsin's Children in Need of Protection and Services (CHIPS) statute was revised to include prenatal substance abuse as "unborn child" abuse and a woman who persists in abusing alcohol may be taken into custody.[5,6] Clinicians must be familiar with laws on the limits of confidentiality in their state (Table).

In addition, many people view alcoholism from the moral vantage point. Pregnant women who continue to drink during pregnancy are morally to blame despite the fact that alcohol and drug addiction are illnesses that require treatment. Furthermore, there are multiple factors that explain why some women drink alcohol during pregnancy. Some women do not know that they are pregnant due to inconsistent periods, gynecologic conditions, or ineffective contraception, and alcohol

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TABLE. Six objections to punitive and coercive legal approaches to maternal decision making[10]

1. Coercive and punitive legal approaches to pregnant women who refuse medical advice fail to recognize that all competent adults are entitled to informed consent and bodily integrity.
2. Court-ordered interventions in cases of informed refusal, as well as punishment of pregnant women for their behavior that might put a fetus at risk, neglect the fact that medical knowledge and predictions of outcomes in obstetrics have limitations.
3. Coercive and punitive policies treat medical problems such as addiction and psychiatric illness as if they were moral failings.
4. Coercive and punitive policies are potentially counterproductive in that they are likely to discourage prenatal care and successful treatment, adversely affect infant mortality rates, and undermine the physician–patient relationship.
5. Coercive and punitive policies directed toward pregnant women unjustly single out the most vulnerable women.
6. Coercive and punitive policies create the potential for criminalization of many types of otherwise legal maternal behavior.

abuse may be associated with mental health problems[7] or socio-economic difficulties.[8,9] It is well known that punitive interventions are ineffective approaches to alcohol addiction and may ultimately be harmful to both the mother and the unborn child. The following table discusses the American Congress of Obstetricians and Gynecologists′ position on legal approaches to maternal decision making.

A fetus may have separate interests that are either equal to or greater than those of a pregnant woman. In the 1999 landmark US case of the State vs Deborah Z, a woman was charged with attempted murder for drinking alcohol heavily during pregnancy and immediately prior to delivery. However, the mother was not held criminally liable on the basis of the ruling that the fetus does not have the legal status of "persons."[11,12] A fetus′ status may increase over time with increasing months of gestation and the concept of expanded fetal rights have evolved since the Roe vs. Wade case of 1973. Some states adhere to the "born alive" rule. The fetus must be born alive before the woman is criminally charged for any injury that occurs in utero but some states limit liability to the point when the fetus is viable.[6]

Many healthcare groups advocate avoidance of punitive interventions and a focus on the primary prevention of FAS, a public health issue. The Centers for Disease Control (CDC) over the years have funded several FASD regional centers across the United States. Funding has also been provided to help train clinicians to provide screening and brief intervention (discussed in more depth in another paper in this issue) in an effort to prevent FAS.[13] The educational curriculum from the CDC has promoted the concept of alcohol-related problems within the biomedical model that is based on the premise that alcohol dependence is a neurological disorder, related to disturbance of function of neurotransmitters such as dopamine, serotonin, GABA, and glutamate.[14]

Beyond the issue of alcohol dependence, more than half of all women of childbearing age (18–44 years) reported some alcohol use, and one in eight reported binge drinking in the past month.[15] Binge drinking is currently defined as four or more drinks in one occasion.[16] In 2010, the Centers for Disease Control and Prevention (CDC) also awarded a grant to the National Organization on Fetal Alcohol Syndrome (NOFAS) in order to increase awareness of FASDs and strengthen prevention efforts at the local, state, and national levels. NOFAS not only provides opportunities for prevention but has also developed a list of resources on FASD in each state.[17] There are also state-wide interventions with funding provided for prevention, drug recovery awareness events, and increased access to addiction treatment.[18]

Conclusion

In reviewing the legal, ethical, epidemiological, and medical issues involved in the prevention of fetal alcohol spectrum disorders, some experts believe the public health approach can help reduce prenatal alcohol exposure.[19] This approach incorporates three levels of interventions: primary approaches focused on stopping maternal drinking before problems arise; secondary approaches involving early detection and intervention specific to pregnant women with drinking problems; and tertiary approaches addressing the need to change the behavior of high-risk women—especially those who already have children diagnosed with an FASD.[20] Legally restraining women from exposing fetuses to the harms of alcohol use has ethical implications and would reach a small number of women. Therefore, it would not achieve the goal of preventing alcohol exposed pregnancies. Efforts to legally restrain women from alcohol abuse during pregnancy neglects the large number of women of childbearing age who are actively drinking while sexually active prior to their knowledge of the pregnancy and inadvertently exposing fetuses to the harmful

effects of alcohol. This punitive approach does not address addiction and prevents women from trying to seek prenatal care.[6] There are studies of pregnant women who use alcohol and drugs. These women do not want to hurt their babies and are interested to make changes necessary to ensure their baby′s health.[21] Primary prevention education is important but when a woman is drinking during pregnancy, clinicians can provide care that respects the woman while protecting her unborn infant. This can only happen when clinicians are educated about addiction, the dangers of alcohol use in pregnancy, and the ethical issues involved.

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