Virtual Mentor
American Medical Association Journal of Ethics
September 2007, Volume 9, Number 9: 611-614.

Clinical Case
Pregnant Women Who Smoke: A Challenge to the Patient-Physician Relationship
Commentary by Jennifer Hernandez, MD, and Scott Roberts, MD

Ms. Davis had many attributes that suggested she would become a successful parent. She was pleased with her current career position, had a strong support network of friends and family, and enjoyed a healthy relationship with her partner. She began prenatal care early in her pregnancy and was now at 20 weeks. The pregnancy had a single complication.

"I know what you are going to ask me," she began defensively as Dr. Golden stepped into the room. "Yes, I am still smoking. You have told me the risks at each of my visits: low birth weight, preterm birth, placental abnormalities, sudden infant death syndrome," she listed. "I just cannot seem to quit. Each time I think I have gathered enough willpower, all it takes is the sight of another smoker before I start having these terrible cravings again. All of my friends smoke. The baby's father smokes. I *do* care about the health of my baby, but this addiction is very strong. I almost think that going through the physical and emotional upheaval of quitting now would be worse for my baby. I can't help but also feel that this is ultimately my body and my choice. Wouldn't you agree, Dr. Golden?"

Commentary
Ms. Davis is a healthy young woman in the 20th week of her pregnancy. The pregnancy has gone well with one exception—cigarette smoking—a problem that Ms. Davis understands but has been unwilling and unable to change. She is not alone. About 22 percent of women over the age of 18 smoke—that's 23 million American women [1]. And although the smoking rate during pregnancy has decreased considerably over the years, it remains at about 12 percent (down from 20 percent in 1989) [2].

The risks of smoking in pregnancy are well known—low birth weight (due to preterm birth or fetal growth restriction), placental abruption, fetal deaths, and sudden infant death syndrome (SIDS). These complications have all been linked to cigarette smoking, but it is unknown how many cigarettes cause the respective harms. Is it one cigarette a day? One pack a day?—we do not know. What we do know is that eliminating smoking during pregnancy would reduce infant deaths by 5 percent and reduce the incidence of individual low-birth-weight infants by 10.4 percent [3]. Stopping smoking before becoming pregnant is ideal, but discontinuing as late as the third trimester eliminates much of the reduced birth weight caused by maternal smoking. But Ms. Davis has heard all this before, and she continues to

smoke. So what is the next step for her physician and for many of us who face this same maternal-fetal conflict everyday?

Balancing Patient Autonomy and Fetal Well-Being

The general principles that guide health care professionals include a responsibility to save or preserve life, relieve or minimize suffering, and avoid harm. The ethical theories that guide these professional principles are nonmaleficence (do no harm) and beneficence (do good). Individual patients have autonomy—a capacity, or at least potential, for self-determination (self-governance and freedom of choice) [4]. Patient autonomy is a firmly established value, and implicit in the concept is the necessity for informed patient consent. Informed consent means that individuals who are being offered a medical opinion—be it medications, surgeries, or substance abuse rehabilitation—are given objective information about the risks and benefits of a procedure or therapy so that they can make educated decisions about their plan of treatment, including refusal of care. Informed refusal by any competent nonpregnant patient is absolute, but once a fetus is involved, the "two-patient" model comes into play, and informed refusal is suddenly questioned. In the two-patient model the pregnant woman and fetus are neither physically separate nor indistinguishably fused [5]. Because of this, a physician's concern about fetal well-being sometimes supersedes a woman's judgment about what is best for her and her unborn child.

An example of a woman's autonomy being overridden by concern for the health of a fetus is the case of Melissa Rowland, pregnant with twins, who was charged with the murder of her stillborn child when she rejected the medical advice to have a cesarean delivery for oligohydramnios and fetal growth restriction while both of her twins were still alive. Ms. Rowland agreed to the cesarean 11 days later for the remaining viable twin after the demise of the growth-restricted fetus. The murder charges were dropped when she pled guilty to child endangerment due to her use of cocaine during pregnancy [6]. Ms. Rowland's competence was never doubted, but because her informed refusal was considered detrimental to her fetus, her autonomy was not absolute. Not only was her autonomy not guaranteed, but her informed refusal was considered criminal.

Most appellate courts have held that maternal decisions regarding medical treatment take precedence regardless of presumed fetal consequences of those decisions. In South Carolina, however, a woman was convicted of homicide after the birth of a stillborn due to regular use of cocaine during the pregnancy [7]. These examples are related to illegal drug use, but could they be a prelude to the future of maternal versus fetal rights? Ms. Davis, our patient, is only using tobacco. But when she delivers a low-birth-weight infant that requires extensive time in the neonatal intensive care unit or dies of SIDS, should she be held responsible? Where do we draw the line? But more importantly, on what basis do we decide where to draw the line?

First and foremost, we must uphold the importance of the patient-physician relationship. We must treat our patients with respect and dignity in order to form a

therapeutic alliance. This is particularly true in the case of substance abuse and rehabilitation. It is undeniable that addiction, be it tobacco, alcohol, illegal drugs, or anything else, is a disease—a compulsive disorder that requires medical attention. Techniques that have been shown to help patients stop smoking include counseling, cognitive and behavioral therapy, hypnosis, acupuncture, and pharmacologic therapy [3]. Ms. Davis has clearly been counseled, but that approach has not been successful. Women who smoke cite weight control, stress reduction, anxiety relief, and social support as reasons why they were drawn to and continue smoking. Physicians should discuss these factors with patients who smoke as a way to better understand the reasons for the addiction and why it persists.

Ms. Davis states that her partner and friends all smoke. Bringing the baby's father in for a prenatal visit and a joint counseling session may give the Davises motivation to quit together. Do they want their newborn to be in a household filled with secondhand smoke? Having her significant other's support and possibly even a "quitting buddy," may be all Ms. Davis needs to work towards a smoke-free pregnancy.

Although these cases can be frustrating for a physician, the fundamental goal of optimizing the outcome of the pregnancy should never waver. That said, however, we must also remember that medical knowledge has its limitations and medical judgment is fallible. We may anticipate certain outcomes from certain behaviors, but we never know for sure. It is our responsibility as physicians to counsel, inform, and advise. But the autonomy of the patient must be upheld and respected, even if a woman's autonomous decision seems not to promote our beneficence-based obligations to the fetus. We face difficult dilemmas everyday as physicians, and maternal-fetal conflict is one of the most difficult. We are, however, not the police, nor should we resemble them. In order to champion the health of children, we must champion the rights of the mothers who bear them—and that, as physicians and members of society—is our biggest challenge of all.

References

1. Christen AG, Christen JA. The female smoker: from addiction to recovery. *Am J Med Sci*. 2003;326(4):231-234.
2. Cunningham FG, Gant NF, Leveno KJ, Gilstrap LC 3rd, Hauth JC, Wenstrom KD. *Williams Obstetrics*. 22nd ed. New York, NY: McGraw Hill; 2005:209.
3. American College of Obstetricians and Gynecologists. ACOG Committee Opinion Number 316. Smoking cessation during pregnancy. *Obstet Gynecol*. 2005;106(4):883-888.
4. Informed consent. In: American College of Obstetricians and Gynecologists. *Ethics in Obstetrics and Gynecology*. 2nd ed. Washington, DC: American College of Obstetricians and Gynecologists; 2004:9-17. www.acog.org/from_home/publications/ethics/ethics009.pdf. Accessed July 30, 2007.

5. American College of Obstetricians and Gynecologists. ACOG Committee Opinion Number 321. Maternal decision making, ethics, and the law. *Obstet Gynecol*. 2005;106(5 Pt 1):1127-1137.
6. Minkoff H, Paltrow LM. Melissa Rowland and the rights of pregnant women. *Obstet Gynecol*. 2004;104(6):1234-1236.
7. Affidavit in Support of Arrest Warrant D-038033 (Feb. 5, 1992), *State v Whitner*, No 92-GS-39-670 (SC Ct Gen Sess Pickens County 1992).

Jennifer Hernandez, MD, is a fourth-year resident in obstetrics and gynecology at the University of Texas Southwestern Medical Center at Dallas. Her primary interest has been in clinical obstetrics and infectious diseases. She is currently pursuing a fellowship in maternal-fetal medicine.

Scott Roberts, MD, is an associate professor of obstetrics and gynecology at the University of Texas Southwestern Medical Center at Dallas. He is on the maternal-fetal medicine staff, and his primary interests are in clinical obstetrics, infectious diseases, and epidemiology.

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental.

The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.