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CLINICAL CASE
Directive Counseling about Becoming Pregnant
Commentary by Frank A. Chervenak, MD, and Laurence B. McCullough, PhD

Dr. Brooks picked up the first chart of the day at the free clinic where she had worked for just a few months since finishing her residency. Her first patient was Jessica, a 25-year-old, here for a new patient visit.

"Hi, Jessica. I'm Dr. Brooks, one of the primary care doctors here. What brings you in today?"

Jessica responded, "I just want to make sure that I'm as healthy as I can be before I get pregnant."

Dr. Brooks began to take Jessica's medical history. She seemed very healthy, with no major medical problems. Jessica had been pregnant twice and she had delivered two healthy infants without complications. But when Dr. Brooks asked about her kids, Jessica became quiet. As it turned out, Jessica and her boyfriend, the children's father, had not seen them in over a year, after they were removed from her home by child protective services. "They said we weren't caring for them properly, not feeding them enough, that sort of thing," said Jessica. "but I always thought they seemed OK."

Dr. Brooks was taken aback, but managed to say, "That must be really difficult."

"Yeah," agreed Jessica, "and that's why my boyfriend and I want to have another baby. I miss my babies, and I want to try again. In fact, I wanted to ask you, do you have any advice for me? Is there anything else I should do to help me get pregnant?"

Dr. Brooks paused. Jessica seems not to have known how to care for her first two children, but now she wanted to have another baby? What if this one were neglected and faced years of suffering or worse? Dr. Brooks didn't want to think about it. As she tried to gather her thoughts, Jessica waited for an answer.

Commentary
A general rule in obstetric ethics is that the decision to become pregnant is a personal decision that has a medical component. There are medical conditions, such as poorly controlled diabetes, that increase the risk of morbidity and mortality to the pregnant woman, fetal patient, and future child that should be considered. Recommending that a woman take such information into account in her decision making and that pregnancy be postponed until the medical condition is well managed are matters of

professional responsibility [1]. We emphasize that making recommendations, i.e., directive counseling when the recommendations concern the medical aspects of pregnancy and when they have a reliable evidence base, does not violate respect for the patient's autonomy, because recommendations do not control the woman's decision-making process. Nor is making recommendations coercive, because the concept of coercion includes the attempt to control decision making by making threats [2].

In this case, the patient has no medical condition that might justify directive counseling. However, based on past history (which appears to include negligence resulting in failure to thrive, which has deleterious, irreversible, long-term consequences for child development) the biopsychosocial well-being of a future child is at stake. Jessica's psychosocial well-being is also at stake, because the removal of a third child from her custody would be psychosocially traumatic.

These biopsychosocial considerations, while not medical conditions, are ethically significant in comprehensive clinical judgment about the patient's well-being and, with respect to a future child, that child's best interests, the protection of which is the core principle of pediatric ethics [3]. The latter ethical consideration creates an obligation on the part of the obstetrician to protect a future child from preventable harm, especially when that harm is serious, far-reaching, irreversible, and likely to occur.

The best interests of any child are protected and promoted when the child is raised by his or her birth mother, her partner or spouse, and involved family members. Being raised by foster or adoptive parents should not be judged to be harmful to a child's interests; the best (being raised by biological parents) should not become the enemy of the good. The pregnant patient's interests and the best interests of a future child will be furthered if she can have a successful pregnancy and keep her child. The future child's interests will be furthered by good parenting, including being cared for by foster or adoptive parents. Obviously, it is biopsychosocially in Jessica's interest to have a successful pregnancy and keep her child.

Achieving a successful pregnancy—i.e., adhering to an appropriate plan of self-care throughout pregnancy and delivery—is not unrelated to Jessica's addressing the causes of her neglect of her existing children and correcting them. Being able to keep the child from her next pregnancy will, in all likelihood, depend on addressing these causes. They could include undiagnosed and untreated mental illness, a history of abuse of the patient as a child, or abuse by her boyfriend. These and other potential reasons for Jessica's neglect of her children should be carefully investigated and a plan of care developed to ameliorate them. The plan should be coordinated with Child Protective Services, so that Jessica can be assured that she will indeed be able to keep her third child and possibly regain custody of her other children. Successful management of these factors will help improve the outcome of her pregnancy, because, now confident in her ability to parent a child, she will be more likely to

become an effective partner to her physicians in the management of a third pregnancy.

We emphasize that the scope of legitimate clinical ethical judgment does not include the obstetrician's deciding that Jessica should not become pregnant because she has been found to be an unfit parent by the courts. To be sure, obstetricians can contribute expert judgment about such matters as Jessica's adherence to an effective plan of self-care during pregnancy. Whether she should become pregnant again, however, is a judgment beyond the competence of obstetricians to make. The obstetrician also has no competence to decide whether being raised in a single-parent household is or is not consistent with the best interests of the child, for the simple reason that many single parents are successful in parenting their children. With adequate preparation and support, Jessica could be a successful parent.

There is an important obstetric ethics take-home lesson from this aspect of this case. Physicians, including obstetricians, get themselves into preventable ethical conflict very quickly when they go beyond the limits of the expertise supported by evidence-based reasoning and the scientific and clinical competence it creates. It would therefore be corrosive to Dr. Brooks's professional integrity for her to make any judgment about whether Jessica should become pregnant again. The above ethical argument supports only making recommendations as to the timing of and preparation for a successful pregnancy.

These clinical ethical considerations warrant a preventive ethics approach to giving Jessica directive counseling [4]. It is clearly in a future child's interest and in Jessica's interests for her to postpone pregnancy until she can become responsible for the rearing of a child. The physician should therefore recommend postponement of pregnancy and refer Jessica to appropriate social services counseling. She should also assure Jessica that she will have her full professional support in implementing this recommendation.

There are no legal tools available to the obstetrician to enforce such a recommendation. The obstetrician will therefore have to use the tools of ethics, especially respectful persuasion: developing a plan of care and recommendations that support Jessica's values concerning having a successful pregnancy and becoming a responsible parent. Such recommendations justifiably include effective prevention of pregnancy during the several months or more that Jessica will need to get her life better organized and to develop the support systems she will need during pregnancy and parenting.

Jessica might not cooperate and might become pregnant without waiting. Is this sufficient reason to end the patient-doctor relationship? The risks of pregnancy, should she cooperate with prenatal care, can be managed. It is not the case that the obstetrician can reliably predict that the fetal patient and future child will be at high risk of serious, far-reaching, and irreversible harm. The reasoned answer to our question is therefore no.

Should clinical ethical obstetric judgment change if Jessica were seeking medical help beyond ensuring that she is medically healthy to initiate a pregnancy? Suppose, for example, that her concern was infertility and that she is seeking assisted reproduction. In such circumstances, the physician has the power to control whether and when Jessica might attempt to initiate a pregnancy. What ethical considerations should guide the obstetrician in the use of such professional power?

Again, the dual focus should be on Jessica's ability to undertake and successfully complete a pregnancy and the best interests of the future child, especially with respect to her keeping the child she will bear. The above ethical considerations apply. The obstetrician is not ethically justified in making the judgment that it would be better for Jessica and society that she not become pregnant; such a social judgment is beyond the obstetrician's competence. Recommending that Jessica postpone assisted reproduction, however, would be ethically justified. Assisted reproduction is an elective procedure and, therefore, the obstetrician has more latitude in deciding whether to offer it. However, the reasoning about such a decision should not appeal to personal judgments about Jessica's parental fitness but to expert clinical judgment that she has not adequately prepared to become pregnant.

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