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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

What Might It Mean to Have a Right to Bear a Pregnancy Peacefully?

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Abstract

This commentary on a case considers how physicians should respond when their patients' health is compromised by physical and social factors. Especially when they are pregnant, patients must feel secure in their access to food and to care provided during appointments.

Case

Dr R is an OB/GYN caring for CC, who is 28 weeks pregnant. CC has high blood pressure and is at risk of developing preeclampsia. Dr R stresses the importance of taking the prescribed medication to help control her blood pressure, resting, and avoiding salt and stress.

CC lives in a historically disinvested, redlined community that faces infrastructural neglect and food insecurity and is downwind from a plant that processes municipal waste. CC takes 2 buses and a train to get to her appointments with Dr R, and recent closure of a critical bus route between CC's neighborhood and affluent areas of the city means that CC must walk to catch the train and second bus to see Dr R.

When CC arrives for her next appointment, her blood pressure is 160/95 mm Hg. "I take my blood pressure medication as prescribed, but, as hard as I try, I struggle to rest and avoid stress. It took me over 2 hours to get here today."

Dr R wonders, "How can anyone gestate peacefully under conditions in which CC lives?" and considers how to respond to CC's concerns.

Commentary

Reproductive justice is defined by SisterSong Women of Color Reproductive Justice Collective as "the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities."[1] The patient CC described in the case above encounters several obstacles in her quest to have her child in a safe manner. First, CC lives in a neighborhood still reeling from historic redlining, where environmental hazards are rampant. While the SisterSong definition of reproductive justice mentions parenting children "in safe and sustainable communities," it should also include the human right to bear a pregnancy in a community with access to food, health care, and transportation, a right that CC certainly

cannot exercise. In this paper, I will explore this right and the tensions that Dr R experiences as her clinician in trying to address CC's obstacles to peaceful gestation.

Obligations to Pregnant Patients

According to the scope of practice on the website of the American College of Obstetrics and Gynecology, "The combined discipline of obstetrics and gynecology requires extensive study and understanding of reproductive physiology; including the physiologic, social, cultural, environmental, and genetic factors that influence disease in women."[2] The vision of the organization "is an equitable world in which exceptional and respectful obstetric and gynecologic care is accessible to all."[2] Thus, Dr R's role includes supervising a healthy pregnancy from a medical point of view, as well as helping to address the numerous social determinants of health that affect CC's pregnancy. Accordingly, Dr R needs to ask CC not only about her physical symptoms, but also about the social determinants of health, such as environmental hazards, that affect her pregnancy.

Dr R's responsibilities toward CC as her OB/GYN align with the core principles of bioethics set forth by Beauchamp and Childress.[3] The principle of autonomy, which focuses on the right of an individual to self-determination to make informed decisions, dictates that Dr R respect CC's decision to carry a pregnancy safely or her decision to not carry the pregnancy if she so desires. Beneficence refers to Dr R's obligation to act in the patient's best interest in both treating the patient and removing possible harm. In this case, Dr R must both provide medical care and assist in mitigating the challenges that CC faces in her pregnancy and in accessing this medical care. Nonmaleficence, which is the principle of causing no harm, dictates that Dr R refrain from doing harm to CC. In fact, one could argue that allowing CC to continue with her pregnancy in her current conditions could be considered an act of harm and therefore reinforces Dr R's role in ensuring more than just the medical safety of her patient's pregnancy. Justice, which emphasizes equity and fairness, manifests here as reproductive justice, ensuring that CC should have the same opportunity for a safe pregnancy as anyone else, regardless of where she lives. This issue is particularly crucial, given the astronomically high rates of maternal morbidity and mortality in the United States, with severe maternal morbidity being even higher in rural communities, which tend to have high rates of poverty, than in urban communities.[4]

Achieving Peaceful Gestation

While Dr R's role in providing prenatal care is clear, the question remains of the extent to which Dr R can help CC to achieve a safe pregnancy—in particular, of the scope of Dr R's role as an individual clinician and the concrete steps she can take to help CC.

The tension between Dr R's role in providing health care to CC and in addressing social determinants of her health is apparent in possible steps she can take to reduce CC's high blood pressure and factors contributing to it. As a medical practitioner, Dr R can control CC's blood pressure through medications and through increased visits to help track fetal well-being through ultrasounds. CC's high blood pressure could be physiological, either due to CC's chronic hypertension or to preeclampsia caused by her placenta.[5] In either case, it is important to control and track preeclampsia to avoid complications of hypertension during pregnancy, as hypertensive disorders of pregnancy are the leading cause of maternal and perinatal mortality.[5] However, psychosocial stress can also increase blood pressure by increasing cortisol levels.[6] Dr R cannot as easily address CC's psychosocial stress merely with medication. Indeed, part of the care for

increased blood pressure during pregnancy includes additional monitoring. For example, weekly antenatal fetal surveillance is recommended for those with controlled chronic hypertension in addition to the 12 to 14 prenatal visits already recommended.[7] CC, whose blood pressure does not appear well controlled, might require even more visits.[8] These additional visits might contribute to further stress for CC, who already struggles to access the clinic in the first place.

Which steps can Dr R take to mitigate this stress and help CC achieve a healthier pregnancy?

Clinician-level actions. Consistent with the bioethical principle of beneficence, it is important that Dr R understand the problems her patients face and provide culturally sensitive care to her patients. While cultural competence can have several definitions, most, such as Betancourt et al's, emphasize the ability of clinicians and systems "to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs."[9] Knowledge of patients' culture should extend beyond intentional beliefs and traditions to include the environments in which they live and how they affect their day-to-day lives and behaviors.[9]

Therefore, providing culturally competent care means that Dr R must not only understand CC's beliefs and traditions but also be aware of resources that exist in her clinic and be able to take advantage of the expertise of others on the care team, such as social workers, who can help address problems that patients face that she might not have time to address herself. For example, it would be important for Dr R to know if there are any transportation resources that CC can use in the short-term, such as a ride service. She can also assess CC for her level of food security and, if needed, try to help connect her with services like the Special Supplemental Nutrition Program for Women, Infants, and Children that can help her access food. Furthermore, she can refer CC to social work or other resources within the clinic. She should also stay up-to-date on issues that are directly affecting the patients at her clinic, such as the current bus route closures, and advocate for her practice to provide resources to mitigate the effects of such events on patients. In addition to staying up-to-date on what affects her patients, she should stay current on literature on innovative approaches to problems faced by her patients. It should be acknowledged, however, that many of these action steps are challenging due to limited clinician time and pressure to see as many patients as possible.

Practice-level actions. Innovative approaches are necessary to help patients overcome structural factors that impede care and that are outside the immediate control of patients and clinicians. There are several methods that have been explored in the literature that Dr R's practice could possibly integrate into care delivery. For example, the COVID-19 pandemic necessitated the innovation of various remote approaches to pregnancy monitoring. Virtual prenatal care has been explored and shown promise for patients and health care clinicians without compromising health outcomes.[10] Reducing numbers of visits has also been shown to not adversely affect pregnancy outcomes for low risk-pregnancies,[10] although patient satisfaction has been reduced.[11] While virtual visits and decreasing the number of visits might be feasible options for low-risk pregnancies, these options would be more challenging for CC, who is already entering pregnancy at higher risk of a poor outcome due to her chronic hypertension.

There are also some innovations that would help with monitoring higher-risk pregnancies. For example, remote self-monitoring of blood pressure, among other measures, has been shown to be a safe alternative to in-person visits.[10] An advanced neonatal epidermal (ANNE) sensor has been developed for pregnancy that monitors vital signs, which could help predict major complications in pregnancy, such as hemorrhage, hypertensive disorders of pregnancy, and sepsis.[4] Given that remote self-monitoring does not increase maternal complications,[10] justice dictates that evidence-based methods be devised that can make prenatal visits more accessible to all, bearing in mind that some people in rural and low-income communities might not have access to the infrastructure necessary to participate in virtual visits.[4] While some of the results reported are only preliminary, CC's practice should stay up-to-date on the literature to provide the most culturally competent care.

Additionally, the fact that Dr R's clinic sees several patients from CC's neighborhood could justify creating infrastructure, such as a clinic, in that area, which would make care more accessible to patients in need. While building a new clinic would be a financial investment, it could ultimately reduce stress for patients by decreasing transportation time to appointments, thereby enabling them to attend more appointments without having to worry about time being lost to transportation that might otherwise be devoted to their jobs or childcare. Such a clinic should be located along public transit routes where many patients live and access neighborhood-specific resources. New infrastructure represents a medium-term solution to providing care for the patients in CC's neighborhood, allowing them to gestate more peacefully. In the long-term, systemic changes should focus on building clinics in diverse urban and rural neighborhoods to reduce patients' travel times to clinics.

Physician as advocate. While Dr R is not responsible for changing the systems of inequity that led to CC's more challenging pregnancy, physicians should continue to advocate for measures that would improve the social conditions of their patients across the socioeconomic spectrum, such as increasing access to care and decreasing health care costs. The American Medical Association *Code of Medical Ethics* recommends that such advocacy be accomplished through "informational campaigns, non-disruptive public demonstrations, lobbying and publicity campaigns, and collective negotiation, or other options that do not jeopardize the health of patients or compromise patient care."[12] It is essential that clinicians continually put patients first in their advocacy in accordance with the principles of beneficence and nonmaleficence, while also seeking justice for their patients and their patients' communities. In addition, clinicians can help their patients register to vote to create change within their own communities.[13] While advocacy can address issues of justice that face patients, physicians already face obstacles to providing optimal patient care. Adding advocacy to physicians' other responsibilities could compound their stress.

Choice Promoting Peace

The multiple stresses of pregnancy necessitate that people be able to choose whether and when to be pregnant. Access to contraception and to abortion are imperative for people to have control over their reproductive lives. The decision of whether to get an abortion is the point at which one consents to pregnancy and all the risk that it entails, since the act of intercourse itself is not directly correlated with pregnancy. Without access to abortion, which is banned or restricted in many states at this time,[14] people are not able to consent to their pregnancies and could be placed in a stressful position of being pregnant on top of managing their other responsibilities, which can include

other children. Thus, without access to abortion, people are forced into gestating without peace and in a way that does not honor their bodily autonomy. Indeed, some states, such as Texas and Louisiana, are even criminalizing key clinical responses to miscarriage complications and not allowing exceptions for abortion in medical emergencies unless a patient has a life-threatening condition.[15,16] Legal impediments to abortion could further deprive pregnant people of peace due to fear of complications, even in wanted pregnancies. Thus, access to safe abortion should be one of the many priorities that physicians like Dr R advocate for in order to provide optimal care for their patients like CC and allow them to have peaceful pregnancies.

It is essential for Dr R to look beyond CC's pregnancy to the life that she will create for her child. Will the child be raised in a safe community? What about environmental pollution? Will the family be able to access nutritious and affordable food? Physicians should try to advocate for measures that would reduce stress for all their patients across the lifespan.

Overall, physicians must address patients' social determinants of health in order to provide culturally competent care that reduces their stress and enables them to feel peace. Patients cannot do their best by their physical health unless they feel secure in accessing food, unless they can physically get to their appointments, unless their many sources of stress can be mitigated. Principles of bioethics obligate members of the profession to seek to create better conditions for their patients through advocacy.

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Editor's Note

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