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Ethical Issues in the Treatment of the Pregnant Patient

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Ethical principles and the rights of the mother and fetus for the provision of proper medical and dental care are closely intertwined. These principles are based on the fact that care is actually provided to two individuals. Since the mother is the life support of the fetus, the medical and dental status of the mother should be optimized during pregnancy. Therefore, necessary medical and dental treatment should not be denied to any female patient because of pregnancy.

Dental procedures, however minor, are associated with increased patient anxiety levels, the need for imaging, and the administration of medications. For these reasons, elective dental procedures should be postponed until postpartum. However, when a pregnant patient is in need of emergency, preventive, or restorative treatment, the aforementioned reasons may force the dentist to refuse treatment because of concern for the mother and the unborn child and the fear of liability and litigation if something happens to the pregnancy and the fetus. Denial of treatment, however, raises serious ethical issues. Thomas Raimann (2016), in response to the question whether it is ethical for dentists to refuse seeing pregnant women until after they give birth, laid out the ethical principles of the ADA Code of Ethics that particularly apply in the dental management of the pregnant patient (Box 1.1).

The principle of patient **Autonomy** (self-governance) and **Involvement** states that

“The dentist should inform the patient of the proposed treatment in a manner that allows the patient to become involved in treatment decisions.” Patient involvement in treatment decisions is highly desirable and ethical; however, pregnant women who have medical needs during pregnancy should not be expected to weigh the risks and benefits when they have to decide whether to proceed with a proposed treatment whose impact on the fetus is unknown. This is an impossible demand; no one can weigh unknown risks and benefits. On the other hand, a straight denial of treatment by the dentist without patient involvement becomes a unilateral decision and thus ethically questionable.

The principle of **Nonmaleficence** (do no harm) expresses the concept that professionals have a duty to protect the patient from harm. Under this principle, the dentist's primary obligations include keeping knowledge and skills current. Denying treatment to a pregnant patient violates this principle in the sense that it is evidence of lack of knowledge on the dentist's part. Evidence-based studies have shown that necessary dental procedures can be performed during the second trimester of pregnancy without an increased risk for serious medical adverse events, spontaneous abortions, preterm deliveries, and fetal malformations. The conservative approach of discouraging treatment because of lack of knowledge about the effects of a procedure and/or medication is not typically erring on

Box 1.1 Ethics in the dental management of the pregnant patient.

Applicable principles of the ADA Code of Ethics

- Principle I: Autonomy, Involvement
- Principle II: Nonmaleficence
- Principle IV: Justice
- Principle V: Veracity

the side of fetal safety; rather, it suggests a lack of knowledge about whether it is riskier for the fetus to be exposed to a medication or to the effects of untreated maternal morbidity. According to Lyerly *et al.* (2008), in the absence of information about the safety and efficacy of medications, pregnant women and their healthcare providers are left with two unsavory options: take a drug, with unknown safety and efficacy, or fail to treat the condition, thus leaving the woman and fetus vulnerable to the consequences of the underlying medical problems.

Under the principle of **Justice** (“fairness”), a “dentist has a duty to treat people fairly.” Moreover, “the dentist’s primary obligations include dealing with people justly and delivering dental care without prejudice” and “dentists shall not refuse to accept patients

into their practice or deny dental service to patients because of the patient’s sex.” Refusing to treat a pregnant patient could be interpreted as discriminating against her unjustly and thus disregarding the ADA Code.

The **Veracity** principle (“truthfulness”) refers to the dentist’s primary obligations which include respecting the position of trust inherent in the dentist–patient relationship, communicating truthfully and without deception, and maintaining intellectual integrity. The dentist is not truthful if denying treatment to a pregnant patient on the grounds of potential harm to the mother and fetus, when scientific evidence does not support that the pregnancy and the fetus are at risk.

The most serious ethical issues arise in cases of life-threatening conditions, such as head and neck infections, severe maxillofacial trauma, and locally aggressive benign and malignant tumors. These conditions will be discussed later in the book. Under those circumstances, treatment decisions for a pregnant patient necessitate a choice between saving her life and that of the fetus, or other dramatic trade-offs. In such cases, Puls *et al.* (1997) stated that there is general consensus (especially in the wake of the Angela Carder case; Box 1.2) that the primary consideration

Box 1.2 The Angela Carder case.

Angela Carder (née Stoner) was diagnosed with Ewing’s sarcoma at the age of 13 years. Her prognosis was dismal but following chemotherapy and radiation, she managed to survive and remained in remission for several years. She got married and with her doctors’ approval she became pregnant.

In 1987, in her first week of the third trimester of pregnancy, she was found to have recurrence of her disease with lung metastases. She had already fought hard to survive and she requested to be treated again with chemotherapy and radiation which had contributed to her years in remission, in spite of the risks

to the fetus. She was admitted to George Washington University Hospital, in Washington DC, where she was deemed a terminal case. As a result of her condition, there was disagreement as to whether she should be treated, exercising her right to save or prolong her life, at the expense of the life of the fetus. Although her condition deteriorated and she was running out of time, Angela did not elect to have an emergent C-section.

This caused concern among the hospital risk managers who, fearing a lawsuit from pro-life organizations, requested a court hearing on the issue, providing legal representation for

Angela, the fetus, and the hospital. At the hearing, her family and her attending physicians all testified against performing a C-section, based on low survivability for the patient and her expressed desire not to go through with the procedure. Angela was not able to testify during the hearing because of her very poor physical condition. The testimony that tipped the balance in favor of an emergent C-section was that of a neonatologist, not familiar with her condition, who testified that the fetal survival rate was 60%. Interestingly, the same fetal survival rate applies also to pregnant women in good health who are at the same gestational age. Angela's attending oncologist was not asked to testify, although he had expressed the view that the procedure was inadvisable for the patient and the fetus.

The court eventually issued an order for an emergent C-section to be performed, although

Angela strenuously objected to it. Only one of the hospital's obstetricians reluctantly agreed to perform the procedure without an informed consent and against the will of the patient. Following the C-section, the fetus is purported to have survived for 2 hours. Angela endured the procedure, was informed about the fate of the fetus, and died 2 days later.

Eventually, in April of 1990 after a legal battle, the US Appellate Court ruled that all previous decisions be annulled and that Angela Carder had the right to make her own decisions relative to her health and the health of her fetus. It was the first Appellate Court decision to take a stand against forced C-sections. The case stands as a landmark in United States case law establishing the rights of pregnant women to determine their own healthcare.

Adapted from Thornton and Paltrow (1991).

should be saving the life of the mother. Charles Weijer (1998) points out, however, that in some cases a pregnant patient's decision to refuse treatment and sacrifice herself

for her child should be counted as an autonomous decision worth respecting, and that it should not be assumed that only self-interest decisions can be autonomous.

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Further Reading

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