Reproductive Intrusions: Evidence and Ethics

Comment on:
Minkoff, Vullikanti and Marshall, "The Two Front War on Reproductive Rights—When The Right To Abortion Is Banned, Can The Right To Refuse Obstetrical Interventions Be Far Behind?

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Feminist bioethicists have long shed light on the indignities and injustice of reproductive intrusions, be they coerced gestation or forced interventions during pregnancy and birth. Writing about the aftermath and implications of the *Dobbs* decision, Minkoff, Vullikanti, and Marshall (2024) reemphasize that compelling a person to carry a pregnancy to term and forcing a pregnant person to undergo unwanted interventions are two sides of the same coin: with pregnancy, a person's liberty is severely circumscribed in both cases.

Even well before *Dobbs*, pregnant people were forced to undergo interventions without their consent. Minkoff et al. highlight tragic cases of obstetrical violence and violations of bodily integrity, and they note that, typically, interventions (including those that a pregnant person might want to refuse) are ostensibly done on behalf of the fetus. Forced interventions are indeed often couched in terms of "fetal benefit". It is the assumption that intervening will reduce risk and/or offer some advantage to the fetus that grounds the worries surfaced by Minkoff et al. However, there is a profound mismatch between forced interventions and the evidence base that underlies them.

Take the case of Samantha Burton, who was coercively held at Tallahassee Memorial Hospital (FL) in 2009 because her physician wanted her to maintain bed rest due to signs of premature labor (Minkoff and Lyerly 2010). Yet the evidence base for bed rest is lacking. Systematic reviews of the literature do not support bed rest for the prevention of preterm birth, and have cataloged numerous harms, including venous thromboembolism (blood clots), bone

demineralization, muscle deconditioning, psychological suffering, and harm to families (McCall et al. 2013). As a result, the American College of Obstetricians and Gynecologists has taken a position against its routine use (2016); others (including one of us) have argued that even with consent, "therapeutic" bed rest is inconsistent with ethical medical practice, and that it should only be offered in the context of a clinical trial (McCall et al. 2013). Other routine obstetrical interventions, such as CTG (electronic fetal monitoring during labor), suffer from similar evidence gaps regarding fetal benefit against well-established harms (Alfirevic et al. 2017). And, still, the practices are so entrenched that debates continue to focus on whether pregnant people can refuse them, rather than whether they are ethical to prescribe in the first place (Wolf 2021).

Perhaps more familiar are profound evidence gaps for the use of medications to treat illness in pregnancy, resulting in questions about which drugs are safe and what dose to prescribe in the context of pregnancy to optimize efficacy and minimize toxicity. Here, worries about forced intervention are less pronounced, though Minkoff et al. give a nod to the prospect in circumstances where prevention of vertical transmission of (and thus fetal protection from) infectious disease is at issue. This (fear-invoking) context aside, for treatment of many maternal diseases that can affect fetal health—e.g., depression, multiple sclerosis, asthma, epilepsy (and sometimes, still, infectious disease)—it is often the *physician* who will refuse to prescribe a treatment or preventive, even where its *benefits* are either well-documented or likely to outweigh uncertainties about dosing or risk. Thus while pregnant people face the (growing) specter of unwanted interventions in a context of "default invasiveness" that characterizes

labor and delivery (Wolf 2021), they also face the prospect of being forced to continue pregnancy in the absence of medical treatment needed to protect their health and that of their offspring from chronic or emergent disease.

Taken together, this Janus-faced pattern of intervention (Lyerly et al. 2009) suggests two things where forced treatment is concerned. First, such intrusions are not in fact about minimizing risk or promoting benefit to fetal health; indeed, in Paltrow and Flavin's noted study (2013) of arrests and forced interventions on pregnant women in the United States from 1973 to 2005, they found that the majority of cases were not contingent upon scientific evidence of significant risk or actual harm to the fetus that could be prevented by intervention. Nor were the forced cesareans of Angela Carder or Samantha Burton, whose infants' lives both ended with delivery.

Rather, we see a clear disjunct between forced intervention and evidence that it would prevent harm, indicating other motivating factors at play—racism, misogyny, and risk distortions, to name a few. In this vein, we echo others who have surfaced how forced interventions during pregnancy reflect and reinforce structural racism (Gilliam and Roberts 2021; Paltrow and Flavin 2013), how misogynistic violence operates in systematic ways (Manne 2017), and how reasoning about risk during pregnancy and birth is often based on fear instead of evidence (Lyerly et al. 2009). Forced intervention is a kind of enforcement that tracks certain social currents, but protection of fetuses is not one of them.

Second, and relatedly, forced treatments and forced gestation foreground the distorting notion that pregnant people and fetuses are separate entities whose interests are paradigmatically opposed. Abortion has long been noted to reinforce a notion of the maternal-fetal relationship as *generally* adversarial, leading to the dominant framing of ethical issues in reproductive medicine as "maternal-fetal conflict" and a tendency to regard the medical treatment of pregnant persons (or testing of interventions to protect their health) as a threat to fetal health (Waggoner and Lyerly 2022). But conflict is an inaccurate, impoverished, and harmful way to describe the maternal-fetal relationship. Inaccurate because in most cases, maternal and fetal interests are aligned, even in of cases of refusal (e.g., bed rest or CTG); impoverished because it fails to attend to the complexities of the maternal-fetal relationship and the fact that risk trade-offs in pregnancy are both unavoidable and reason for compassionate care and shared decision-making, not punishment; and harmful because it has been a source of blind spots around the ethics of research and treatment (Waggoner and Lyerly 2022), and has contributed to a culture in obstetrics in which maternal maltreatment, including coercive and punitive interventions, is widespread (Mohamoud et al. 2023).

Ultimately, we agree with Minkoff et al. in their conclusion that the appropriate tact at this precarious moment is not to continue to debate the moral status of the fetus. And we agree that it is always important to reinforce as ever that pregnant persons are persons first, whose rights to bodily integrity are inviolable. But we believe that there is a third, often neglected strategy, which is to emphasize that forced interventions are almost never to the benefit of anyone—pregnant person, fetus, or family. We can do so by first attending to evidence, for

which most forced interventions is either lacking or associated with physical and psychological harm to the pregnant person and the fetus or child; and second by resisting the urge to "balance" maternal and fetal interests and instead reframe debates in ways that recognize the ways in which they are intertwined. It is often noted that the best way to ensure the health of a fetus is to ensure the health of the pregnant person. Honoring pregnant peoples' needs, autonomy, and bodily integrity would be an important step in the right direction.

REFERENCES

Alfirevic, Z., D. Devane, G. M. L. Gyte, and A. Cuthbert. 2017. Continuous cardiotocography (CTG) as a form of electronic fetal monitoring (EFM) for fetal assessment during labour. *Cochrane Database of Systematic Reviews* 2(CD006066), 1–137. doi: 10.1002/14651858.CD006066.pub3.

American College of Obstetricians and Gynecologists (ACOG). 2016. Management of preterm labor. Practice Bulletin No. 171. *Obstetrics and Gynecology* 128 (4):e155–64. doi: 10.1097/AOG.0000000000001711.

Gilliam, M., and D. Roberts. 2021. Why reproductive justice matters to reproductive ethics. In: *Reproductive Ethics in Clinical Practice*, ed. J. Chor J. and K. Watson K. New York: Oxford.

Lyerly, A. D., L. M. Mitchell, E. M. Armstrong, L. H. Harris, R. Kukla, M. Kuppermann, and M. Little. 2009. Risk and the pregnant body. *Hastings Center Report* 39 (6):34–42. doi: 10.1353/hcr.0.0211.

Manne, K. 2017. *Down Girl: The Logic of Misogyny*. New York: Oxford University Press.

McCall, C. A., D. A. Grimes, and A. D. Lyerly. 2013. 'Therapeutic' bed rest in pregnancy: Unethical and unsupported by data. *Obstetrics and Gynecology* 121 (6):1305–8. doi: 10.1097/AOG.0b013e318293f12f.

Minkoff, H., R. U. Vullakanti, and M. F. Marshall. 2024. The Two Front War on Reproductive Rights—When The Right To Abortion Is Banned, Can The Right To Refuse Obstetrical Interventions be Far Behind? *American Journal of Bioethics* in press.

Minkoff, H., and A. D. Lyerly. 2010. Samantha Burton and the rights of pregnant women twenty years after *In re A.C. Hastings Center Report* 40 (6): 13–15. https://doi.org/10.1002/j.1552-146X.2010.tb00069.x.

Mohamoud, Y. A., E. Cassidy, E. Fuchs, et al. 2023. *Vital Signs*: Maternity Care Experiences — United States, April 2023. *MMWR Morb Mortal Wkly Rep* 72:961–967. DOI: http://dx.doi.org/10.15585/mmwr.mm7235e1.

Paltrow, L. M., and J. Flavin. 2013. Arrests of and forced interventions on pregnant women in the United States, 1973–2005: Implications for women's legal status and public health. *Journal of Health Politics, Policy and Law* 38 (2):299–343. DOI 10.1215/03616878-1966324.

Waggoner, M. R., and A. D. Lyerly. 2022. Clinical trials in pregnancy and the "shadows of thalidomide": Revisiting the legacy of Frances Kelsey. *Contemporary Clinical Trials* 119:106806. https://doi.org/10.1016/j.cct.2022.106806.

Wolf, J. 2021. “They said her heart was in distress”: The electronic fetal monitor and the experience of birth in the U.S.A., 1960s to the present. *Icon* 26(2), 33–61. https://www.jstor.org/stable/27120654.