# Maternal-fetal care starts and ends with the mother

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Over the last several years, maternal-fetal intervention has rapidly evolved and challenged those who provide care to pregnant women in many ways. Although fetal treatment began in the 1960s with the introduction of intraperitoneal transfusions by obstetrician Dr A. William Liley,[1] it has become a field largely managed by pediatricians. In an effort to facilitate the transition from intrauterine to neonatal life with instantaneous access to pediatric specialists, most fetal care centers are now located in pediatric hospitals that offer luxurious birthing facilities to families faced with the worst uncertainty of their lives after the prenatal diagnosis: ongoing pregnancy management and birth (usually by scheduled cesarean) of a child with a congenital condition. The focus has shifted from the mother to the fetus. As the physical location of maternal-fetal care has shifted to the pediatric setting, so has the control of maternal-fetal care. Obstetricians and maternal-fetal specialists have not offered much resistance to the shift from obstetric to pediatric decision making.

Obstetricians and pediatricians are both necessary participants, but the ideal model of care has not been determined. The appropriate training, personal characteristics, and qualifications needed to guide a family through the complex medical and ethical issues that arise have not been studied. The report in this issue of the journal by Brown et al[2] is a welcome addition to the literature of both specialties.

Brown and colleagues[2] surveyed pediatric and maternal-fetal medicine specialists to characterize their approach to 3 commonly faced clinical scenarios in fetal care. The study highlights the inherent differences in attitude toward maternal-fetal care, which can be traced to the divergent training experience of the 2 groups. For example, obstetricians questioned in the survey were significantly more likely to support pregnancy termination for a prenatal diagnosis of trisomy 21, congenital diaphragmatic hernia, or spina bifida. Pediatricians ascribed a significant value to consultation with a pediatric provider prior to a decision about pregnancy termination for Down syndrome but were less likely to provide information about or refer families for this service. This highlights the emphasis of each specialty on their primary patient; obstetricians recognize maternal autonomy as primary while fetal autonomy is the focus of pediatric care providers.

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This is not surprising. How would a pediatrician understand the complex issues associated with pregnancy termination? Where would an obstetrician learn about health care complications and outcomes of children and adults with Down syndrome? A wise physician once said, "What the mind doesn't know the eyes can't see." This statement illustrates the current chasm between the specialties of obstetrics and pediatrics that originates during formative years of training and significantly affects the practice of fetal medicine.

The training of an obstetrician is uniquely centered on not 1 but 2 patients. There are occasions when the life of one cannot be saved at the expense of the other. Given the incidence of miscarriage and stillbirth in the population, discussions of pregnancy loss are not infrequent for obstetricians. Prenatal diagnosis, which begins and often ends within the care of an obstetrician, is the only aspect of medicine in which pregnancy loss (termination) is considered a management option and a direct reflection of the value placed on maternal autonomy. Obstetricians not surprisingly lack training in prognostic outcomes and options for management of pediatric conditions after birth. A study of obstetricians' opinion on fetal prognosis after an abnormality was identified revealed significant variation in the judgment of quality of life and classification of severity of the condition.[3]

The purpose of pediatric training and medicine is to save young lives. The death of a child or the inability to repair an injury or fix a problem is considered failure by many and not an experience routinely encountered in a general pediatric practice. The pediatric community experiences an inordinate pressure to provide maximal treatment of every child except when treatment would prolong the process of dying or be considered futile and inhumane.[4] A survey of neonatologists reported a perceived burden to overtreat infants because of medical-legal threat and potential loss of federal funding without maximal treatment of every child.[5]

Maternal-fetal care occurs only during pregnancy. When fetal intervention is chosen, it necessarily exposes the mother to some level of risk that all obstetricians recognize and are obligated to consider. Pediatricians readily identify with the fetus as a patient, view the rights of the mother as less clearly defined, and assume, most often correctly, that the mother will be willing to accept almost any risk on behalf of their unborn child. The language of the first American Academy of Pediatrics (AAP) ethics committee statement on fetal therapy suggested that a physician might intervene physically on behalf of the fetus without maternal acceptance if judicial authorization is obtained.[6] Subsequent legal actions and policies were aimed at protecting the fetus without regard for maternal bodily integrity. This astounded obstetricians trained to respect maternal life and autonomy above all else. In response, the American College of Obstetricians and Gynecologists (ACOG) issued a

committee opinion that firmly supported maternal autonomy with no exception in which maternal choice should be undermined by perceived fetal indication.[7] Both organizations recently collaborated to resolve these independent and differing statements, with the publication of a joint committee opinion on maternal-fetal intervention and fetal care centers in 2011.[8]

This latest joint document asserts, "A pregnant woman's right to informed refusal must be respected fully." The publication acknowledges the difficulties that can arise in the care of the pregnant woman and fetus. Management conflicts are certain to arise as pediatric providers perceive their primary obligation to the fetus while obstetric providers consider maternal interest first with fetal outcomes a close second. The origin of this divergence is easy to understand; it is rooted in what the mind is trained to know and limited by what the eyes can see.

Obstetric providers must advocate for their patients and retain control of overall care, which is directed in the joint AAP and ACOG statement on maternal-fetal intervention and fetal care centers. Pediatricians should continue to provide ongoing expertise in intervention and counsel regarding prognosis for those conditions whose natural history is known best to them. The need for further research and guidance in this expanding field of fetal medicine is apparent by the results of the work by Brown and colleagues.[2] As the management of pregnancies with fetal diagnosis continues to evolve, we must recognize that optimal care will only come with interdisciplinary collaboration that should be championed by the obstetric community. Ultimately, we must learn from each other and provide training opportunities for those working in fetal care so that our minds are open to a common understanding of the complexity of both maternal and fetal issues related to the prenatal detection of fetal disorders. ■

## REFERENCES


**1.** Liley AW. Intrauterine transfusion of fetus in hemolytic disease. BMJ 1963;2:1107-9.

**2.** Brown SD, Ecker JL, Ward, JR, et al. Prenatally diagnosed fetal conditions in the age of fetal care: does who counsels matter? Am J Obstet Gynecol 2012;206:409.e1-11.

**3.** Bijma HH, Wildschut HI, Heide A, et al. Obstetricians' agreement on fetal prognosis after ultrasound diagnosis of fetal anomalies. Prenat Diagn 2004;24:713-8.

**4.** Rebagliato M, Cuttini M, Broggin L, et al. Neonatal end-of-life decision making. JAMA 2000;284:2451-9.

**5.** Lantos JD, Tyson JE, Allen A, et al. Withholding and withdrawing life sustaining treatment in neonatal intensive care: issues for the 1990s. Arch Dis Child 1994;71:F218-23.

**6.** Fetal therapy–ethical considerations. American Academy of Pediatrics. Committee on Bioethics. Pediatrics 1999;103:1061-3.

**7.** American College of Obstetricians and Gynecologists Committee on Ethics. ACOG committee opinion no. 321: maternal decision making, ethics, and the law. Obstet Gynecol 2005;106:1127-37.

**8.** American College of Obstetricians and Gynecologists Committee on Ethics; American Academy of Pediatrics Committee on Bioethics. Committee opinion no. 501: maternal-fetal intervention and fetal care centers. Obstet Gynecol 2011;118:405-10.