

# Reproductive Issues in Women With Multiple Sclerosis: Ethical Considerations

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## ABSTRACT

Addressing the reproductive concerns of women with multiple sclerosis (MS) is vital for comprehensive care. Contraception, conception, pregnancy, and breast-feeding present many vexing questions to the woman with MS. The risks and benefits of using disease-modifying therapy during the various stages of a woman's reproductive life are topics that need to be discussed. The physician's primary duty is to the patient; however, the physician must also consider the fetus and later the child. In helping guide the patient in making medical decisions, the physician must take into account the patient's motivation for those decisions, including family obligations, cultural norms, and patient values. The physician is instrumental in providing the patient with sound, nonjudgmental information and advice so that she may make a well-informed, autonomous decision about her health and her disease.

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## Case

A 27-year-old woman with relapsing-remitting multiple sclerosis (MS) presented to her neurologist because of a several-day history of progressive, painful loss of vision in the left eye. She was 27 weeks pregnant. Before her pregnancy, she used glatiramer acetate (GA) as the disease-modifying therapy (DMT) for her MS. The medication had been discontinued at 12 weeks of gestation when she discovered that she was pregnant. Physical examination was consistent with a severe acute left optic neuritis. The patient was treated with methylprednisolone 1000 mg IV daily for 3 days. Symptoms resolved within a month. At 38 weeks of pregnancy, the patient delivered a healthy baby boy. At that time, the patient elected not to resume GA while breast-feeding. The patient agreed to reinstitute DMT once she was finished breast-feeding her child. At 5 months postpartum, she developed vertigo and diplopia. The physician recommended that the patient discontinue breast-feeding and start DMT to protect her from further relapses. She wanted to defer treatment and continue breast-feeding her child. The neurologist was concerned that this decision would adversely affect her health and well-being, as well as that of her child.

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Drs Morgan-Followell, Nicholas, and Weisleder discuss the unlabeled use of disease-modifying therapies during attempts at conception and during pregnancy.

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**DISCUSSION**

Currently, there are no evidence-based guidelines to aid the physician in making recommendations regarding conception, pregnancy, and breast-feeding. This patient's case raises the following questions:

1. What is the physician's duty to the patient?
2. What is the physician's duty to the patient's child?
3. How does the physician help the patient make medical decisions that are in her, her child's, and the family's best interests?

MS is an autoimmune disease characterized by inflammation within the brain and spinal cord that ultimately leads to demyelination. MS is the leading cause of nontraumatic disability in young adults.<sup>1</sup> Women are twice as likely as men to develop MS, and the first presentation of symptoms may occur during the years of childbearing potential. Therefore, counseling women on the potential impact that MS and its disease-modifying therapy has on pregnancy and motherhood is important for comprehensive patient care. For an extensive review of the medical issues and evidence, see "Multiple Sclerosis in Pregnancy" by Dr Patricia Coyle in this issue of **CONTINUUM**.

**The Physician's Duty to the Patient, the Fetus, and Later the Child**

When caring for pregnant women with MS, neurologists should determine whether their duty is to the patient, the fetus, or both. The answer to this conundrum depends on whether the fetus is conferred the status of patienthood (ie, whether the physician has fiduciary duties toward the fetus). Only the mother can confer such status to the fetus. The ethical concept of the fetus as a patient has considerable clinical significance.<sup>2</sup> If the fetus is also a patient, then the physician's recommendations must also include the fetus' best interest. If the fetus is not a patient, then the physician's responsibility to act in the fetus' best interest is no longer obligatory.

Obstetricians have long wrestled with this issue. In most instances, the conundrum arises when the mother's actions or intended actions are potentially harmful to the fetus. It is worth considering models used to evaluate perinatal ethical dilemmas. The maternal-fetal relationship can be viewed using one of the following three models.<sup>3</sup> In the first, mother and child are considered as a single entity, where the fetus is a part of the woman's body. As such, the physician only has one patient—the mother. Critics point out that a fetus is not a body part and cannot be treated as such.<sup>2</sup> In the second model, mother and fetus are viewed as separate entities. In this so-called reductionistic or zero-sum-game model, the physician has two patients—the mother and the fetus, each with a set of rights. The risk is that should rights-based tensions between the mother and the fetus arise, rights afforded to one will have to take precedence over the rights of the other. The third model acknowledges that mother and fetus have a unique and indivisible relationship and should be viewed as a maternal-fetal dyad. The expectation is that the mother will act in the best interest of the dyad.<sup>4</sup> This model, dubbed "the professional responsibility" model by Chervenak and colleagues,<sup>5</sup> is autonomy and beneficence based. The American College of Obstetricians and Gynecologists (ACOG) endorses the professional responsibility model<sup>6</sup> and maintains that as a competent adult, the pregnant woman has a claim to autonomy. Because the fetus lacks capacity and

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cannot possess values and beliefs, the fetus has no autonomy claim, and the physician has no autonomy-based obligations to the fetus.<sup>7</sup> It is only when the pregnant woman confers the status of patienthood to the fetus (ie, an autonomous decision of the mother expressed to the treating physician or physicians) that the fetus gains beneficence-based rights.

### **Helping the Patient Make Medical Decisions in Her, Her Child's, and the Family's Best Interests**

An interpretation of autonomy in line with the concept of the mother-child dyad is one in which the neurologist provides the patient, in nonjudgmental fashion, with all the information necessary to help her make informed consent or refusal decisions. According to this interpretation, the mother has the right to make decisions about her health with the knowledge that those decisions may have consequences for the fetus and, after birth, for the child. The information provided to the mother must be honest and unbiased. Respecting the mother's autonomy and decisional capacity recognizes that she is better positioned than anyone else to make decisions that take into account her own values, circumstances, and concerns, as with any other health care decision made by autonomous adults.<sup>6</sup>

When counseling a pregnant patient, the neurologist will have to explain the direct and indirect effects that available treatment options (including no treatment) will have on her and the fetus. In circumstances when the mother's decision could affect her future health status, the discussion should also broach the future impact of her decision on the child and the family unit. The conversation will need to start with a delineation of risks and benefits. For example, if resuming DMT in the early postpartum period precludes breast-feeding because exposure of the child to DMT transmitted via breast milk carries risk, then the child would not receive the immunologic and emotional benefits of breast-feeding. Conversely, potential benefits of DMT may include a decreased number of MS relapses and slower accrual of disability. This direct benefit to the mother is associated with indirect benefits to the child. On one hand, prevention of relapse or accrued neurologic disability through the use of DMT may allow the mother to effectively care for her child. On the other hand, avoiding DMT in the postpartum period creates a risk of relapse and disability, which can impair the mother's ability to care for the child and may also take a financial toll through loss of income or hospitalizations.<sup>8</sup>

At this time, no evidence-based guidelines exist concerning use of DMT during attempts at conception, pregnancy, or breast-feeding. However, based on the literature available, some DMTs may be considered in situations in which the therapy is clearly needed and the potential benefits outweigh the presumed risk. The neurologist has autonomy- and beneficence-based obligations to the patient, as she has presented herself for treatment. The neurologist's duty to a pregnant patient's fetus may be less clear; however, in the great majority of cases, the woman confers the status of patienthood to the fetus, which means the neurologist must consider the fetus' beneficence and therefore has a duty to the fetus. The rights of the fetus are upheld by the mother's autonomous decisions to maximize her health and her fetus' health.

Comprehensive MS care takes into account the fact that pregnancy is unique to women and that MS influences women's decisions about reproduction not

only physically (ie, in terms of risks of recurrence of disease activity or disability) but also emotionally and psychologically (ie, by provoking anxiety, depression, or guilt about decisions that may adversely affect a woman's health and well-being or that of her fetus or child). Ultimately, it is prudent to discuss reproduction, including planning, conception, pregnancy, and breast-feeding, at the appropriate times with each woman with MS of childbearing potential regardless of disease status. Holding such conversations may be considered "preventive ethics." And while the concept "identify, prioritize, and address systemic ethics issues"<sup>9</sup> was conceived with healthcare systems in mind, the notions can be extrapolated to individual patients. Applying the model to a patient such as the one we are discussing would begin by identifying and prioritizing her wishes about family planning and, with those in mind, establishing treatment plans to address contingencies such as disease exacerbation or accrual of disability.

### CONCLUSION

Following a frank discussion of the risks and benefits of resuming DMT and discontinuing breast-feeding versus deferring DMT and continuing to breast-feed, the physician and patient in this case agreed that when her son reached 12 months of age she would stop breast-feeding and resume GA. The patient and physician agreed that setting a time limit for breast-feeding would be in her son's best interest, as he would receive the benefits of breast-feeding, and in her best interest, as she would be off DMT only for a limited time period, which hopefully would not increase her risk of MS relapse. The patient also agreed to reconsider starting DMT earlier than her son's first birthday if she had recurrent relapses during this time.

The patient declined high-dose corticosteroids to treat her current attack of vertigo and diplopia because she would have needed to discard breast milk and feed her son infant formula.

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