Maternal-Fetal Surgery in the *Dobbs* Era: Ethical Principles Inform Clinical Practice to Protect Pregnant Patients

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Background

Prenatal intervention and maternal-fetal surgery (MFS) encompass a specialized set of novel procedures and surgeries aimed to correct or mitigate the progression of specific congenital anomalies. Since the Supreme Court decision in June 2022 in the case of *Dobbs v. Jackson Women's Health Organization*, an increase in restrictions around access to abortion care for many patients has raised pressing ethical questions around the clinical offering and practice of MFS. As some of the premier fetal care centers in the country are within states now restricting or banning abortions, it is important for providers and pregnant patients to understand what is clinically, legally, and ethically permissible and the discrepancies between them. Furthermore, if the field of MFS is to expand in a climate of increasing polarization around reproductive care, providers must understand the factors influencing patient enrollment and research funding for the specialty.

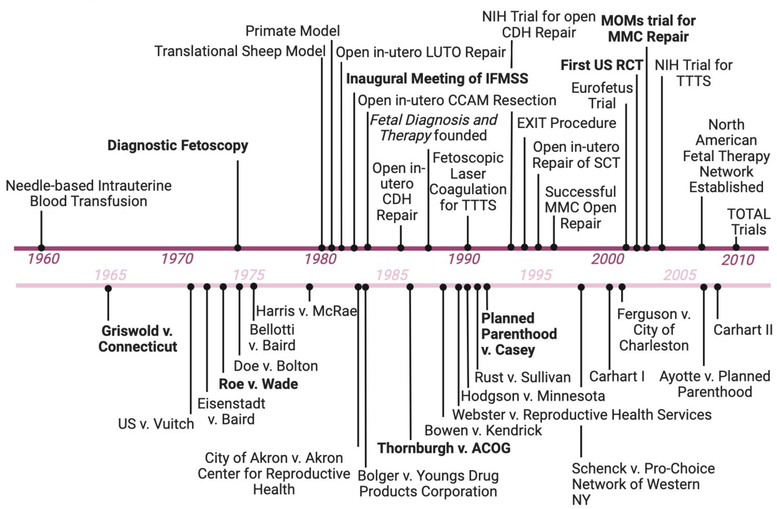


Figure 1. Timeline of the clinical and technological advancement of maternal-fetal surgery and landmark United States Supreme Court reproductive rights cases

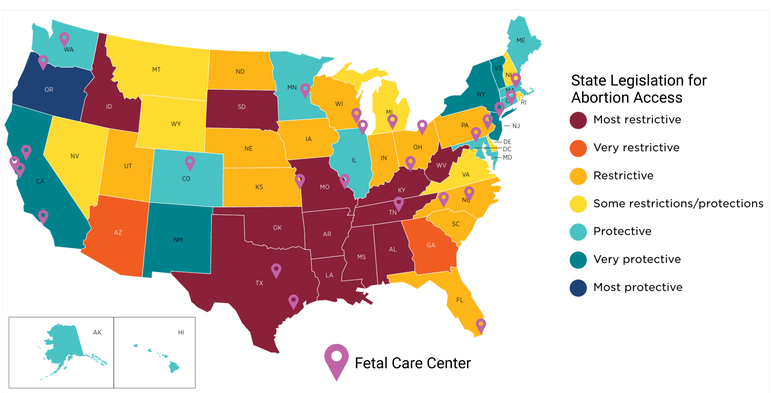
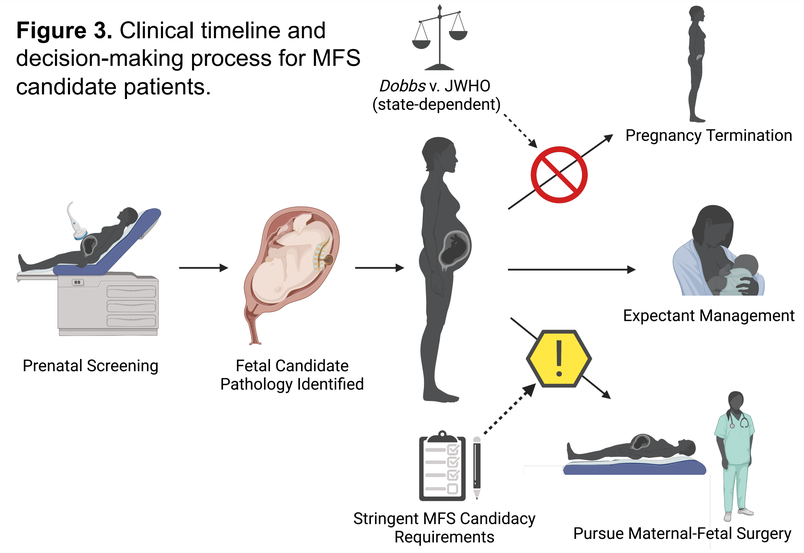


Figure 2. State-dependent map of current restrictions on access to abortion care after Dobbs v. JWHO (2022) with locations of major fetal care centers. Adapted from Guttmacher Institute[1] and Fetal Health Foundation[2].

Clinical Decision Making

MFS-candidate patients must consider risks and benefits of any procedure for themselves and their fetuses. Prior to the *Dobbs* decision, MFS patients were informed of at least three potential courses of action: pursue MFS, terminate the pregnancy, or monitor the pregnancy until the postnatal period (expectant management). These options have diminished in states with restricted access to abortion where termination of pregnancy is conditioned on the fetus' gestational age. Candidacy requirements for the pregnant person considering MFS are stringent and include physical health requirements (e.g., body-mass index), adequate social support, and psychological evaluation. For patients who are not MFS candidates and live in states with hostile legislation towards abortion care the practical number of options decreases from three to one— expectant management. This contingency may potentially coerce patients to undergo MFS when they should not have to. Absent the option for safe termination, pregnant patients may accept additional risk from a sense of obligation to their fetuses and/or a desire to avoid the consequences of compromised fetal health.

Figure 3. Clinical timeline and decision-making process for MFS candidate patients.



Applications for Clinical Practice

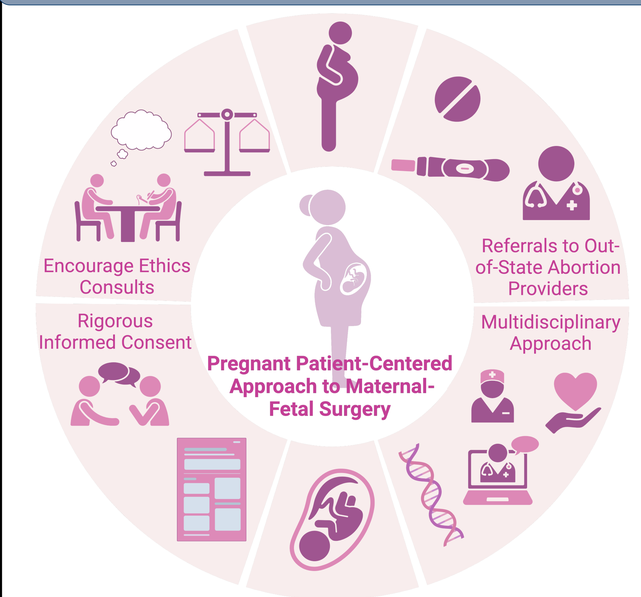


Figure 4. Clinical framework for approaching MFS candidate patients.

Given new restrictions to abortion access in many states, ethical and legal considerations should inform the clinical care of all pregnant patients, including those who are MFS candidates. A thorough risk-benefit analysis for both patients and providers should be conducted in the proper clinical context. As invasive prenatal procedures are performed, it is important to delineate the risks and potential complications of the procedure for patients and their social support systems as an intentional component of the informed consent process. Given the uncertainties inherent in many complex MFS cases, ethics consults should be encouraged at MFS centers, and because fetal care centers invest significant time and resources on their patients, it seems inadequate for them to claim comprehensive maternal-fetal care if they do not also invest resources in helping patients who elect for termination. To increase the clinical options for pregnant patients, out of state referrals for both fetal care centers and abortion care providers should be offered. As always, MFS as a specialty should continue its multidisciplinary approach to patient care, involving healthcare providers from maternal-fetal medicine, pediatric surgery, obstetric anesthesia, neonatology, social work, and ethics consult services, among others. As reproductive healthcare professionals navigate this new era of abortion constraints they should maintain a specialized pregnant patient-centered approach in the clinical diagnosis, management, and treatment of MFS candidates.

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