

Clinical, Ethical, and Legal Considerations in Pregnant Women With Opioid Abuse

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The rising prevalence of women with opioid addiction in pregnancy necessitates understanding of medical, ethical, and legal considerations on the part of obstetricians. In addition to briefly reviewing the medical care of opioid abuse in pregnancy, we offer a careful consideration of the stigmatization of addiction and resultant medicolegal sequelae. We advocate for improved access to opioid maintenance therapy and social services as a means of improving healthful pregnancy outcomes and decry recent trends in the criminalization of addiction nationwide.

(*Obstet Gynecol* 2015;126:474–8)

DOI: 10.1097/AOG.0000000000000991

The dramatic increase in abuse of prescription opioids and heroin throughout the United States has been widely reported by both the media and medical community. Accidental deaths from narcotic overdose have outstripped those from motor vehicle accidents or suicide.¹ Workplace, health care, and judicial costs of the opioid epidemic are estimated to exceed \$50 billion annually. Obstetricians are increasingly encountering reproductive-aged women using illicit substances or participating in opioid maintenance therapy. In fact, 4% of pregnant women report using nonprescription drugs in pregnancy with opioids being the second most prevalent illicit substance behind marijuana.¹ Opioid maintenance

therapy, also termed medication-assisted treatment, mitigates the risks of acute opioid withdrawal in pregnancy as well as allows for gradual, postpartum weaning to counter the high rates of recidivism associated with abrupt cessation of opioids.

Therefore, to effectively and empathetically care for opioid-dependent pregnant women, obstetricians must have basic familiarity with opioid maintenance therapy and recognize the many ethical and legal complexities affecting medical care. Physicians must also be mindful of the layers of stigma that this population faces and seek to provide compassionate, nondiscriminatory care that strives to improve both maternal and neonatal outcomes. To optimize pregnancy outcomes for this vulnerable population, physicians must be vocal advocates for social services and opioid maintenance therapy programs as well as collectively reinforce the fact that criminalizing addiction in pregnancy is both clinically ineffective and ethically inappropriate.

CLINICAL CONSIDERATIONS

Opioids as a class have no proven teratogenicity. The majority of the risks associated with opioid abuse in pregnancy are related to the effects of withdrawal for the patient and her fetus or the concomitant risks of any associated behaviors.² Acute opioid withdrawal carries an increased risk of miscarriage, placental abruption, preterm labor, and stillbirth.² The health risks surrounding substance abuse include an increased risk of infectious diseases such as hepatitis C and human immunodeficiency virus (HIV) from sharing needles, bacterial infections from injecting or skin popping, and sexually transmitted infections from trading sex for drugs or other high-risk sexual behavior. Additionally, there may be exposure to criminal activity and incarceration.² Many women abusing opioids exhibit polysubstance abuse, often as an attempt to self-medicate underlying psychological illness or alleviate withdrawal symptoms with more accessible substances. Women with substance abuse are likely to self-report high rates of poverty, intimate partner violence, a history of

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The authors thank Jennifer Bailit, MD, MPH, for her expertise and assistance with drafting the manuscript.

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Financial Disclosure

The authors did not report any potential conflicts of interest.

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ISSN: 0029-7844/15

physical or sexual abuse, posttraumatic stress disorder, and mental illness.¹

Opioid maintenance therapy was adopted in the 1960s to treat heroin-addicted veterans and has recently been expanded to patients with nonheroin narcotic abuse.³ Traditionally, methadone formed the mainstay of opioid maintenance therapy programs, although the current trend has been toward increased use of buprenorphine. Although opioid maintenance therapy was initially trialed as short-term stabilization in acute withdrawal, the high rate of relapse after treatment led to the current model of long-term, potentially even lifelong, outpatient opioid maintenance therapy.³ The goal of opioid maintenance therapy is threefold: 1) decrease continued high-risk activity, 2) reduce the risk of relapse for the mother, and 3) improve perinatal outcomes by preventing frequent withdrawal during gestation.² Prospective studies have reported a reduced risk of death, criminal activity, and bloodborne infection in heroin addicts on opioid maintenance therapy.³ Clinical information for obstetricians regarding opioid abuse in pregnancy and opioid maintenance therapy protocols is not specifically addressed in this article, although it is available.⁴ Opioid maintenance therapy also allows for cessation of drug-seeking behavior and resumption of normal life activities such as reestablishing social support, parenting, and seeking employment or education. Long-term studies have demonstrated that pregnant women enrolled in opioid maintenance therapy have low rates of resumption of illegal substances and are able to maintain a relatively normal family life.⁵ Alternatively, pregnant women who decline opioid maintenance therapy or women in locations without access to this service may withdraw from opioids in controlled inpatient settings. This approach, however, is resource-intensive, requires a lengthy hospital admission, and is associated with high rates of relapse.²

Traditionally, opioid maintenance therapy utilizes methadone, a longer-acting opiate than pills or heroin. Tightly regulated by the federal government, methadone clinics sometimes have long waiting lists as a result of the increasing demand. Patients face many other barriers to participation including often needing daily appointments to receive their methadone dose.³ "Good behavior" is rewarded with take-home doses and less frequent trips to the clinic. Approved by the U.S. Food and Drug Administration in 2002, buprenorphine is a long-acting opioid agonist-antagonist that has a ceiling effect; it is thus more difficult for patients to accidentally or intentionally overdose and therefore often does not require daily

visits to a clinic. Take-home dosing increases accessibility, preserves confidentiality, and decreases the social stigma of opioid maintenance therapy but may make buprenorphine more likely to be diverted and sold illegally. Unlike methadone, buprenorphine has not undergone rigorous long-term neurodevelopmental studies documenting safety outcomes in infants and children, although studies do demonstrate improved neonatal outcomes.^{2,6} Single-agent buprenorphine (subutex) is typically preferred by health care providers in pregnancy over the buprenorphine-naloxone (suboxone) formulation as a result of the presumed risk of precipitating withdrawal if injected, although suboxone use is thought to decrease medication diversion.² Preliminary studies demonstrate no increased risk of adverse neonatal or maternal outcomes compared with methadone.^{5,6}

Despite the evidence-based clinical benefits of opioid maintenance therapy, initiating and sustaining therapy pose numerous challenges. Side effects of opioid maintenance therapy include sedation, constipation, persistent cravings at lower doses, or withdrawal symptoms with late or missed dosing with both methadone and buprenorphine as well as mental clouding with methadone treatment.⁷ Obtaining daily transportation to centers and arriving on time can pose a difficult challenge for many opioid-addicted women. Daily visits can also result in a loss of anonymity and fear of public shaming, especially when patients are visibly pregnant or bringing children with them to appointments. Access to clinics is limited because physicians licensed to prescribe buprenorphine may only treat a limited number of patients at one time and the opening of new clinics is often met with resistance from local communities or politicians.³ Finally, patients may resent the need for long-term therapy, feeling they have replaced one addiction with another.⁶

A unique consideration of opioid maintenance therapy in pregnancy is neonatal abstinence syndrome, withdrawal symptoms from opioids that some neonates begin to experience within the first 3–7 days of life. Severe neonatal abstinence syndrome requires prolonged hospitalization to observe and treat with decreasing doses of opioids, titrated based on symptoms such as irritability and gastrointestinal distress.² Neonatal abstinence syndrome can occur with both methadone and buprenorphine therapy, although preliminary studies suggest decreased length of hospital stay and treatment times with buprenorphine.⁶ It is important to emphasize that the severity of neonatal abstinence syndrome after birth is dose-independent. Some patients and health care providers mistakenly

try to decrease or wean doses in pregnancy to prevent neonatal abstinence syndrome, which only increases the risk of withdrawal or relapse with its attendant maternal and fetal risks in pregnancy.⁷ Thus, it is important to titrate opioid maintenance therapy dosing to control maternal symptoms of withdrawal, acknowledging that this may include increased dosing as pregnancy progresses as a result of physiologically increased plasma volume and renal clearance.

ACCESS TO CARE, STIGMA, AND THE THERAPEUTIC RELATIONSHIP

Difficulties in accessing medical care for reproductive-aged women compound the challenges detailed here once care has been established in pregnancy. Addicted women may have limited access to contraception and family planning services. Amenorrhea associated with heroin abuse can lead to an uncertain last menstrual period and poor dating. Unplanned pregnancies, once accepted, may be highly desired by women wanting “another chance” after loss of custody of a previous child or fill an emotional void in a chaotic setting dominated by transience and fractured relationships. Furthermore, families may be more willing to shelter these women in the setting of pregnancy as well.

It is crucial to encourage opioid-dependent women to access and maintain medical care. Many without insurance are able to access Medicaid or other safety net services in pregnancy, allowing them access to integrated services for mental health, dental clinics, smoking cessation, and improved nutrition. Services with traditionally long waiting lists—ie, methadone clinics and psychiatry—often become available after a positive pregnancy test, although this continues to be challenging in rural or underserved communities. Prenatal care provides an opportunity to encourage breastfeeding, which is safe on opioid maintenance therapy, and plan for postpartum contraception. Education to dispel myths about neonatal abstinence syndrome and social services involvement after delivery should be addressed during prenatal care as well. Integrated care programs providing medical care, social services, and psychiatric support have been implemented in other countries with excellent reductions in substance abuse and relapse.^{5,8}

Despite the desire to have a healthy neonate, concern about stigmatization from health care providers have been identified as a key deterrent to obtaining prenatal care.² Some women postpone care in an attempt to first become sober. Others completely avoid care as a result of fears about universal drug screening, mandatory reporting to social services, legal ramifications, and fear of losing custody

of other children. Prior suboptimal experiences and outcomes with the health care system and social services can become self-reinforcing.

Stigma and illness are closely intertwined and often coevolve. Extensively described in the literature, the stigmatization of HIV-positive patients provides the groundwork for understanding stigma in other groups. Alonzo proposed that an illness will be stigmatized if the illness is 1) associated with deviant behavior, 2) viewed as the responsibility of the individual, 3) representative of a morally sanctionable behavior, 4) perceived as contagious to the community, 5) associated with an undesirable or unaesthetic death, and 6) poorly understood by society and health care providers.⁹ Addiction in pregnancy meets these criteria. It violates accepted standards of sobriety; sobriety and parenthood are seen as choices, and addiction is attributed to weakness and lack of willpower.¹⁰ The moral connotation of an addict is a degenerate, “sinful” person, a burden to society with frequent involvement with crime, joblessness, theft, and the legal system.^{3,11} The visual aesthetics associated with “addicts” as emaciated, riddled with track marks, and with poor dentition serve as powerful icons of this poorly understood problem. The effects of stigmatizing addiction can take different forms. At its root, stigma is a “powerful and discrediting social label” that denigrates both the self-concept and self-esteem of an individual or group and sullies one’s acceptance by the community.⁹ Stigma is directed at a vulnerable population that already lacks healthful coping mechanisms. The “choice” of pregnancy only further compounds and amplifies this stigma.

Therefore, even the most well-meaning health care provider serving this subpopulation needs to periodically reexamine personal biases that weaken the therapeutic relationship. Caring for opioid-addicted women can be challenging and relationships can easily swing toward adversarial. Health care staff must take care to avoid an “us versus them” mentality. Prenatal visits for opioid-addicted mothers often are time-consuming and resource-intensive, requiring consultation with social work, mental health providers, or completion of prison paperwork. There may be health care provider discomfort with continuing opioid maintenance therapy dosing during the inpatient stay as well as confusion because special Drug Enforcement Agency privileges are not necessary for inpatient prescription, although individual hospitals may limit inpatient prescribing to certain health care providers. Regional anesthesia is effective, but achieving adequate postoperative analgesia can be difficult. Many health care providers are reluctant to

write for additional narcotic pain medications for postsurgical pain despite increased tolerance, altered pain perception, and the ethical imperative to treat pain adequately. Finally, these patients often visit the hospital after their discharge as a result of lengthy neonatal admissions for neonatal abstinence syndrome, leading to further opportunities for friction with staff and difficulties with early maternal–neonatal bonding. Inclusion, education, and reflection must be frequently revisited to effectively deliver compassionate health care.

ETHICAL COMPLEXITIES

The American College of Obstetricians and Gynecologists supports the statement by the National Institute on Drug Abuse that addiction is not a moral weakness but a chronic medical illness.² Reevaluating personal biases, decreasing both perceived and experienced stigma, and optimizing maternal and neonatal health through opioid maintenance therapy exemplify beneficence toward the opioid-dependent pregnant woman. The ethical principle of nonmaleficence also mandates that physicians should avoid using humiliation or negative judgment to encourage women to seek or maintain care. Humiliation and judgment compound the personal and societal burden that pregnant addicts carry because they seemingly violate the societal moral expectation that pregnant women act in the best interest of the fetus.¹² Pregnant women carrying their pregnancies to term bear an ethical obligation to take action to promote the health of the fetus; most women with addiction are highly motivated to pursue healthy pregnancies, yet they are repeatedly discouraged and shamed when they fail to uphold the ideal of sobriety.² In general, women taking harmful substances are not aiming to harm the fetus but are merely responding to an acute psychological and physical need for that substance.¹²

The possibility of neonatal abstinence syndrome exemplifies the ethical complexity of opioid addiction in pregnancy. Although some have characterized addition and opioid maintenance therapy as a potential maternal–fetal conflict because the opioid-dependent woman's drug-seeking behavior and the risk of neonatal abstinence syndrome with opioid maintenance therapy can potentially be detrimental to the fetus, no true conflict exists. Although a frank discussion about neonatal abstinence syndrome is an important part of the informed consent process through shared decision-making when initiating opioid maintenance therapy, it has been proven to improve both maternal and neonatal health outcomes and reinforces the "essential connection between the pregnant woman and the fetus."¹³ The fates of the two

are inextricably linked. Although prolonged inpatient admission for a slow detoxification process combined with social services to ensure an inability to relapse would arguably lead to the absolute best neonatal outcomes, given the overriding consideration of maternal autonomy, limited access to such care, and lack of data demonstrating improved pregnancy outcomes in facilities such as prisons, in general, supporting maternal health will ultimately benefit the best interests of the fetus as well.^{10,14}

Because acute cessation of opioids in pregnancy can lead to maternal and fetal complications, improving access to opioid maintenance therapy maximizes benefit and reduces harm. Limited access to opioid maintenance therapy, whether resulting from a shortage of outpatient clinics and health care providers trained to provide opioid maintenance therapy or the result of practical barriers in accessing care, remains an issue of justice. Furthermore, the principle of formal equality mandates that like risks be treated similarly; punitive policies and procedures that deter care for opioid addiction in pregnancy but provide for care for other medical comorbidities in pregnancy that also pose fetal risk violate this principle. Such practices mistakenly place the interests of the fetus above that of the mother and endanger respect for maternal bodily autonomy and personhood.^{10,13} Although pregnant women have a moral obligation to promote fetal health, supportive rather than antagonistic medical care and societal support services enhance patient autonomy and promote optimal medical outcomes.

LEGAL RAMIFICATIONS AND THE CRIMINALIZATION OF ADDICTION

Societal disapproval of opioid addiction in pregnancy has been increasingly codified into law or public health policy.¹¹ This misguided approach stems from a purported desire to deter negative behavior in pregnancy despite the fact that imprisonment is not associated with improved health outcomes and may trigger the obstetric emergency of acute withdrawal.¹⁴ As of May 2015, 18 states consider substance abuse in pregnancy to be child abuse, and there are increasing reports of women arrested for positive urine toxicology screens in pregnancy.¹⁵ Recent laws that penalize addicts for not seeking care in pregnancy do not acknowledge the barriers to accessing care, even for the highly motivated opioid-dependent pregnant woman.

In practice, these legal sanctions are harmful and deter women from seeking care, creating adversarial relationships between the patients and physicians. Mandating physician reporting of substance abuse

compromises the ethical and legal imperatives of privacy and confidentiality as well as harms the ability to form a therapeutic patient–physician relationship. The negative health and social ramifications from these deterrents to care during pregnancy are further compounded by ever-decreasing access to family planning services. Given that the prevalence of abuse continues to rise despite an increase in sanctions and laws, it is clear that treating addiction as a criminal act is ineffective and inappropriate.

Thus, obstetricians must be clear: addiction is a chronic disease and not a moral failing.^{2,14} Criminally targeting women for chronic health conditions in pregnancy is medically and ethically inappropriate and reinforces societal stigmas. Surreptitious legal encroachments on women's autonomy highlight their continued vulnerable role in society.^{10,12} The pervasive gendered undervaluing of women's health and reproduction is made more problematic when one considers that these legal sanctions are unevenly shared across social strata, often targeting poor and minority women.^{12,16} As providers of health care for reproductive-aged women, obstetricians have a responsibility to provide patient-centered, compassionate care, educate others regarding the chronic disease of addiction and its effect on pregnancy, and promote social and legal change that enhances autonomy and clinical outcomes for both the mother and child.

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