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Person-Centered Pregnancy Options Counseling

This Committee Statement was developed by the American College of Obstetricians & Gynecologists' Committee on Ethics in collaboration with Yasaswi Kislovskiy, MD, MSc, and Mara Black, MD. The Society for Family Planning endorses this committee statement.

Pregnancy options counseling is a person-centered process through which one provides information regarding management options in continuing a pregnancy or not and seeks to understand a patient's values, beliefs, preferences, concerns, and ambivalence regarding pregnancy. In practice, upholding comprehensive person-centered pregnancy options counseling is a nuanced process. A health care professional's ability to enact these ethical principles in their practice may be limited by legal restrictions or institutional culture or both; however, they can use person-centered and shared decision-making frameworks to understand and support their patients. The Society for Family Planning endorses this Committee Statement.

SUMMARY OF RECOMMENDATIONS AND CONCLUSIONS

- **Pregnancy options counseling is a person-centered process through which one provides information regarding management options in continuing a pregnancy or not and seeks to understand a patient's values, beliefs, preferences, concerns, and ambivalence regarding pregnancy.**
- **When providing pregnancy options counseling, clinicians should seek to preserve a patient's reproductive autonomy. The patient's desire to be pregnant or not, and to parent or not, should be explored with the patient using a shared decision-making model.**
- **People should receive options counseling that respects their autonomy and avoids assumptions about desired pregnancy outcomes.**
- **Pregnancy options counseling can include a patient's choice to defer deciding and can allow for uncertainty or ambivalence.**
- **Clinicians should present clear, evidence-based information to a patient on the risks associated with a pregnancy while engaging the patient to understand how risks and benefits of a decision would be valued in the context of their life.**
- **Obstetrician–gynecologists have a responsibility to provide accurate and unbiased information regarding pregnancy options to all patients, regardless of their perception of a patient's**

circumstances and resources (1). This includes scenarios where a clinician is, legally or otherwise, unable or unwilling to provide the full spectrum of pregnancy care options.

- **Obstetrician–gynecologists should consider the ways their own biases may affect their counseling and potentially contribute to systemic inequities in perinatal care, particularly for populations experiencing historical and current injustice. Health care systems should be optimized to support person-centered pregnancy options counseling and avoid contributing to ongoing injustice toward specific populations.**

BACKGROUND

Pregnancy options counseling is a person-centered process through which one provides information regarding management options in continuing a pregnancy or not and seeks to understand a patient's values, beliefs, preferences, concerns, and ambivalence regarding pregnancy. The process of person-centered pregnancy options counseling aims to help the pregnant individual achieve their reproductive goals. It is a vital component of the informed-consent process and the provision of comprehensive health care for a pregnant person (2). Pregnancy options counseling assesses a patient's values and beliefs as they pertain to pregnancy and provides information about options that may include prenatal medical care, abortion, and gestating with or without parenting. Appropriate pregnancy options counseling addresses the following, but does not assume how a patient prioritizes each of these pieces of information within the context of their life and values: 1) risks to the pregnant person of continuing a pregnancy or terminating a pregnancy; 2) fetal status and, to the extent possible, prognosis; 3) and access to resources that reasonably could be anticipated to be needed and may be limited by geography, insurance or financial resources, or local or state policy or programs. Examples of such resources include family planning, maternal or fetal specialized care, pediatric specialized care, educational and childcare resources, and support for families with financial or medical barriers to care.

A shared decision-making framework is crucial to person-centered pregnancy options counseling and is further described in the American College of Obstetricians & Gynecologists' (ACOG) Committee Opinion 819, *Informed Consent and Shared Decision Making in Obstetrics and Gynecology*" (3). Alongside shared decision making, person-centered care considers the whole person and does not narrowly define patients by their relationship to clinical care (4). Unlike ACOG Committee Opinion No. 819, this document focuses on counseling regarding pregnancy continuation and not all of shared decision making in obstetric and gynecologic care. In practice, upholding comprehensive person-centered pregnancy options counseling is a nuanced process. Physicians facing legal or institutional restrictions on pregnancy options may still use the person-centered and shared decision-making frameworks to understand and support their patients.

ETHICAL ISSUES AND CONSIDERATIONS

Person-centered counseling supports reproductive autonomy (5). Reproductive autonomy is considered an individual's "ability and fundamental right to make and act on decisions about their bodies, including…whether to continue a pregnancy" (6). **When providing pregnancy options counseling, clinicians should seek to preserve a patient's reproductive autonomy. The patient's desire to be pregnant or not and to parent or not should be explored with the patient using a shared decision-making model** (3). Clinicians should balance providing information and ascertaining a patient's values and desires without being coercive or directive through the shared decision-making process (7, 8). To support reproductive autonomy for a pregnant patient considering pregnancy continuation or abortion, clinicians should involve patients in an unbiased discussion. Using nonjudgmental language and open-ended questions can help avoid communicating a clinicians' biases (9).

Although not all patients want all options discussed in detail, to support reproductive autonomy, clinicians should be ready to counsel on all options, including abortion, gestation with the goal of parenting, and gestation with the goal of adoption (10). As defined in ACOG Committee Opinion 390, *Ethical Decision Making in Obstetrics and Gynecology*, "Individuals should receive equal treatment unless scientific and clinical evidence establishes that they differ from others in ways that are relevant to the treatments in question (11)." This includes counseling regarding abortion care, care for pregnancies involving complex fetal conditions, and care for pregnancies that are high-risk for the pregnant person (12). Person-centered pregnancy options counseling can allow for limiting discussions that are not providing benefit to the patient. For example, if a patient has expressed understanding of a fetal condition diagnosed prenatally, understanding of the availability of management options, and a clear desire to continue the pregnancy, it would not be person-centered to continue to bring up abortion as an option at every visit if there has not been a significant change in fetal status and additional counseling is not desired by the patient. As well, clinicians who do not provide abortion care for any reason should still counsel

patients about all options (13, 14). It is challenging to uphold the ethical principle of autonomy when health systems have limited access to reproductive health options or when policies and laws create barriers to care (15, 16). To help overcome these institutional, regional, or state-level barriers to person-centered pregnancy options counseling, obstetrician–gynecologists (ob-gyns) ideally would have the unrestricted ability to discuss all options for reproductive health care.

People should receive options counseling that respects their autonomy and avoids assumptions about desired pregnancy outcomes (17, 18). Interactions should be based on a patient's needs and not the assumptions or feelings of clinicians. For example, reflexively offering congratulations for a patient's pregnancy, or condolences for the diagnosis of a fetal anomaly or genetic condition, without an understanding of the patient's experience of these diagnoses may be counterproductive to building trust in the patient–doctor relationship and impede the goals of person-centered pregnancy counseling (19, 20). As a patient considers pregnancy options, the option for pregnancy also may be considered alongside the patient's sense of self and the broader social connections they find meaningful, with a "locus of control" in the patient (21, 22). As noted in ACOG Committee Opinion 819, "A shared decision-making model of informed consent encourages physicians to reframe autonomy as 'relational,' that is, informed by a patient's interpersonal relationships and broader social environment (7)." Thus, if indicated by the patient, including a patient's family members, intimate partner(s), friends, or other community members may be valuable during person-centered pregnancy options counseling.

Pregnancy intentions can include ambivalence. **Pregnancy options counseling can include a patient's choice to defer deciding and can allow for uncertainty or ambivalence.** Among the possible outcomes of pregnancy options counseling is a clear and unambiguous understanding that the patient desires to be pregnant or that the patient desires an abortion. When a patient expresses a decision, it is important that this is respected and that an appropriate plan is made with the patient for the desired care to be provided. However, some patients may not have as clear preferences, or their decisions may change over time. Ambivalence, not making choice, or deferring the decision to later are all also expressions of autonomy. If clinicians perceive a firm decision declaration as the goal of health care discussions, that may unintentionally cause patients who do not express these firm declarations to feel abandoned rather than supported in the shared decision-making process (23).

Pregnancy intentions may change over time. Patients may have ambivalence or fluctuating feelings about their pregnancies, and stigma, criminalization, and concerns about confidentiality can prevent patients and clinicians from fully discussing such feelings. Obstetrician–gynecologists should understand their local limits to confidentiality and clearly communicate those with patients. It is reasonable to not press a patient when it appears they do not want to continue the discussion or to gauge a patient's interest in options based on prior interactions. New information regarding maternal or fetal health may also appropriately prompt the health care team to assess a patient's pregnancy intentions. Still, an episode of pregnancy options counseling can reasonably and appropriately conclude when a patient expresses ambivalence or decision deferral, or even when a patient indicates they are not planning to disclose personal preferences to the clinician. Clarifying whether the patient would like more information to support them may be helpful, without focusing on forcing a disclosure of a decision.

Risk of misconceptions may be inherent to the counseling process but does not preclude providing medical guidance. Clinicians should balance counseling a patient on all options with the possibility that, in discussing an option, they may inadvertently lead the patient to assume that an option is helpful or recommended just because it is discussed by a clinician (24, 25). This does not indicate that ob-gyns should withhold options, but rather they should be very clear when options carry high risk of adverse outcomes. In shared decision making, the clinician does not abdicate their professional responsibility to the patient, and clinicians should share their medical expertise with patients. **Clinicians should present clear, evidence-based information to a patient on the risks associated with a pregnancy while engaging the patient to understand how risks and benefits of a decision would be valued in the context of their life.** For example, when caring for individuals with medical conditions that lead to an elevated risk for adverse outcomes during pregnancy, clinicians should avoid broad directive statements such as, "You should not get pregnant," while also clearly discussing the potential for adverse outcomes and giving evidence-based recommendations. Highlighting the intersection of autonomy with nonmaleficence, it is also true that withholding options that have clear medical benefit, such as withholding abortion care for patients diagnosed with previable and periviable premature rupture of membranes, is unethical and should not be done (26).

Clinicians may feel distress in providing care. An ob-gyn's individual beliefs and biases should not unduly influence pregnancy options counseling. ACOG Committee Opinion No. 385, *The Limits of Conscientious Refusal in Reproductive Medicine*, provides further details (13). When choices are made that the health care team may deem to have a very high level of risk and there is confusion on how to uphold ethical principles, for example,

continuing a pregnancy with high risk of adverse outcomes, the involvement of ethics team members, maternal–fetal medicine specialists, and risk management specialists as available may be helpful to the clinician who is providing care. Transfer of care to access resources for therapy or diagnostics that are not available locally may be reasonable. Respecting a patient's informed decision and providing appropriate care or referral in line with those decisions may, at times, be contradictory to an ob-gyn's personal beliefs about the correct course of action. This can be true in cases in which a pregnancy is continued or ended, although, in either case, a clinician's beliefs should not obstruct standard of care. In addition, ob-gyns who are constrained in their options by local resources, institutional policies, or laws may struggle with "moral injury." This refers to the adverse psychological effects experienced when a clinician is constrained from acting in a way they believe to be right and can include symptoms of guilt, shame, anger, and social withdrawal (27–30). Seeking peer support and counseling can help alleviate these symptoms, and institutions employing clinicians facing moral injury may benefit from addressing the structural causes of this negative effect on their workforce (27).

The structure of health care delivery, and historical and contemporary injustice from these structures and from individuals, may influence pregnancy options. There are significant disparities in access to reproductive care in the United States, and additional factors in a person's life circumstances may exacerbate vulnerability within the context of pregnancy (31). These broader factors can include mental health disorders, disability, lack of transportation access, lack of financial resources, substance use, incarceration, young age, local laws, institutional policies, and any other factor that creates a barrier to full and comprehensive reproductive health options (32, 33). Patients facing these barriers may lack the resources to advocate for themselves to maintain their reproductive autonomy. **Obstetrician–gynecologists have a responsibility to provide accurate and unbiased information regarding pregnancy options to all patients, regardless of their perception of a patient's circumstances and resources (1). This includes scenarios where a clinician is, legally or otherwise, unable or unwilling to provide the full spectrum of pregnancy care options.**

Pregnancy options counseling may be influenced by pre-existing structures of reproductive health care delivery. For example, patients may have already decided about the care they desire before making an appointment. In these cases, an ob-gyn may meet a patient for a clinical visit in a setting that only provides abortions or in a setting that only provides prenatal care without access to abortion. Still, accessing health care can be confusing, and patients may inadvertently present at a center that is not aligned with their reproductive desires. Limited local resources or targeted marketing encouraging use of certain facilities, sometimes in misleading ways such as in the case of so-called crisis pregnancy centers, may affect a patient's ability to present in a care setting that aligns with their needs (34–38). Thus, all reproductive clinicians should be prepared to discuss all pregnancy options no matter the setting in which they practice and be prepared to refer when the desired service is not in line with the practice setting's abilities. Obstetrician–gynecologists should be careful to clarify whether a pregnant person is electing a health care choice that is not preferable to them due to real or perceived lack of access to an alternative option or if their own biases are contributing to inequities in care. **Obstetrician–gynecologists should consider the ways their own biases may affect their counseling and potentially contribute to systemic inequities in perinatal care, particularly for populations experiencing historical and current injustices. Health care systems should be optimized to support person-centered pregnancy options counseling and avoid contributing to ongoing injustice toward specific populations.** Legal concerns around medical care and counseling ideally should not affect a clinician's ability to provide comprehensive pregnancy options counseling. However, clinicians should strive to be aware of the restrictions in their states.

CONCLUSION

Provision of person-centered care through use of shared decision making and consideration of the whole person, and the relationships and social context they identify as important, is a crucial feature of pregnancy options counseling. Person-centered pregnancy options counseling is inclusive of a person's conviction or ambivalence and should seek to preserve a patient's sense of reproductive autonomy as decisions are made to pursue abortion, continue a pregnancy with the goal of parenting, or continue a pregnancy with the goal of adoption. Ideally, legal concerns around reproductive health care should not affect a clinician's ability to provide comprehensive options counseling.

USE OF LANGUAGE

ACOG recognizes and supports the gender diversity of all patients who seek obstetric and gynecologic care. In original portions of this document, authors seek to use gender-inclusive language or gender-neutral language. When describing research findings, this document uses gender terminology reported by investigators. To review

ACOG's policy on inclusive language, see https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/inclusive-language.

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CONFLICT OF INTEREST STATEMENT

All ACOG committee members and authors have submitted a conflict of interest disclosure statement related to this published product. Any potential conflicts have been considered and managed in accordance with ACOG's Conflict of Interest Disclosure Policy. The ACOG policies can be found on acog.org. For products jointly developed with other organizations, conflict of interest disclosures by representatives of the other organizations are addressed by those organizations. The American College of Obstetricians & Gynecologists has neither solicited nor accepted any commercial involvement in the development of the content of this published product.

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