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WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

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Committee on Ethics

This Committee Opinion was developed by the American College of Obstetricians and Gynecologists as a service to its members and other practicing clinicians. Although this document reflects the current viewpoint of the College, it is not intended to dictate an exclusive course of action in all cases.

Alcohol Abuse and Other Substance Use Disorders: Ethical Issues in Obstetric and Gynecologic Practice

ABSTRACT: Alcohol abuse and other substance use disorders are major, often underdiagnosed health problems for women, regardless of age, race, ethnicity, and socioeconomic status, and have resulting high costs for individuals and society. The *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition, defines *substance use disorder* as a pathologic pattern of behaviors related to the use of any of 10 separate classes of substances, including alcohol and licit and illicit substances. In order to optimize care of patients with substance use disorder, obstetrician–gynecologists are encouraged to learn and appropriately use routine screening techniques, clinical laboratory tests, brief interventions, and treatment referrals. The purpose of this Committee Opinion is to propose an ethical framework for incorporating such care into obstetric and gynecologic practice and for resolving common ethical dilemmas related to substance use disorder.

Alcohol abuse and other substance use disorders are major, often underdiagnosed health problems for women, regardless of age, race, ethnicity, and socioeconomic status, and have resulting high costs for individuals and society. The *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition, defines *substance use disorder* as a pathologic pattern of behaviors related to the use of any of 10 separate classes of substances, including alcohol and licit and illicit substances. These behaviors are grouped under the categories of impaired control, social impairment, risky use, and pharmacologic criteria (ie, tolerance and withdrawal) (1). The term "substance use disorder" will be used throughout the document and will be inclusive of these 10 substance classes, including alcohol.

Substance use disorder includes the abuse and misuse of a wide variety of licit and illicit substances, the most common of which are listed in Box 1 (2, 3). (Although tobacco is listed in Box 1, tobacco abuse is beyond the scope of this Committee Opinion.) Prescription medications (included in Box 1) often are categorized separately from illicit substances; however, because these drugs fall into similar pharmacologic classes as illicit substances and also are commonly used in excess, they must be considered in any discussion of this issue. In fact, the nonmedical use of prescription drugs, particularly opioids, sedatives, and stimulants, has reached epidemic proportions in the United States (4).

In order to optimize care of patients with substance use disorder, obstetrician–gynecologists are encouraged to learn and appropriately use routine screening techniques, clinical laboratory tests, brief interventions, and treatment referrals. More detailed guidance on this clinical protocol for the management of substance use disorder is provided in other documents published by the American College of Obstetricians and Gynecologists (the College) (4–6). The purpose of this Committee Opinion is to propose an ethical framework for incorporating such care into obstetric and gynecologic practice and for resolving common ethical dilemmas related to substance use disorder. Based on this framework and underlying ethical principles, the College offers the following recommendations:

- Routine screening for substance use disorder should be applied equally to all people, regardless of age, sex, race, ethnicity, or socioeconomic status. Routine screening for substance use disorder can be accomplished by way of validated questionnaires or conversations with patients. Routine laboratory testing of biologic samples is not required.

- Obstetrician–gynecologists have an ethical responsibility to treat their patients with substance use disorder with dignity and respect and to try to establish a therapeutic alliance with these patients. Obstetrician–gynecologists should familiarize themselves with resources available through their local hospital, community, or state in order to appropriately and effectively refer patients for treatment.
- When a legal or medical obligation exists for obstetrician–gynecologists to test patients for substance use disorder, there is an ethical responsibility to notify patients of this testing and make a reasonable effort to obtain informed consent.
- Obstetrician–gynecologists have an ethical responsibility to follow current best prescribing practices for controlled medications in order to avoid inadequate or inappropriate treatment of pain and patient misuse or diversion (ie, redistribution) of prescription medications.
- Obstetrician–gynecologists should protect patient autonomy, confidentiality, and the integrity of the patient–physician relationship to the extent allowable by laws regarding disclosure of substance use disorder. Physicians should be aware that reporting mandates vary widely and be familiar with the legal requirements within their state or community.
- Obstetrician–gynecologists should, when possible, advocate evidence-based and consensual interventions related to substance use disorder.

Box 1. Substances That Are Commonly Misused or Abused ⇦

- Alcohol (ethanol)
- Cannabinoids (marijuana and hashish)
- Club drugs (methylenedioxymethamphetamine [MDMA], flunitrazepam, and gamma-hydroxybutyrate [GHB])
- Dissociative drugs (ketamine, phencyclidine [PCP] and analogs, *Salvia divinorum*, and dextromethorphan)
- Hallucinogens (lysergic acid diethylamide [LSD], mescaline, and psilocybin)
- Opioids (heroin and opium)
- Other compounds (anabolic steroids and inhalants)
- Prescription medications (central nervous system depressants, stimulants, and opioid pain relievers)
- Stimulants (cocaine, amphetamine, and methamphetamine)
- Tobacco

Data from National Institute on Drug Abuse. Commonly abused drugs. Bethesda (MD): NIDA; 2015. Available at: http://www.drugabuse.gov/drugs-abuse/commonly-abused-drugs. Retrieved April 22, 2015.

- Obstetrician–gynecologists have an ethical responsibility to their pregnant and parenting patients with substance use disorder to discourage the separation of parents from their children solely based on substance use disorder, either suspected or confirmed.
- It is unethical for obstetrician–gynecologists to practice medicine with diminished capacity resulting from the use of alcohol or licit or illicit substances because it may put patients at risk of harm. If obstetrician–gynecologists identify substance use disorder in themselves or their colleagues, they have an ethical responsibility to safeguard patients by modifying their own practice and by seeking guidance from professional organizations to assist with resources for support and intervention.

Ethical Rationale for Clinical Recommendations and Guidelines Related to Substance Use Disorder

This Committee Opinion proposes an ethical rationale for routine screening, brief intervention, and referral to treatment for substance use disorder in obstetric and gynecologic practice. Support for this protocol is derived from the following four basic principles of medical ethics: 1) beneficence, 2) nonmaleficence, 3) justice, and 4) respect for autonomy.

Beneficence

Therapeutic intent, or beneficence, is the foundation of medical knowledge, training, and practice. Positive behavior change arises from the trust implicit in the patient–physician relationship, the respect that patients have for physician knowledge, and the ability of physicians to help patients see the links between physiologic dysfunction and behavior and their physical and psychologic consequences. The Centers for Disease Control and Prevention suggests that all patients be asked about alcohol and substance use regularly and in plain language (7). Routine screening for substance use disorder can be accomplished by way of validated questionnaires or conversations with patients. Routine laboratory testing of biologic samples is not required. There are several examples of evidence-based screening tools that can be used in the evaluation of alcohol and substance use disorder (4–7). It may be most efficient and effective to screen using a team approach, in which nonphysician members of the health care team are educated about screening and how to assist women who have positive screening results.

Obstetrician–gynecologists have an ethical responsibility to treat their patients with substance use disorder with dignity and respect and to try to establish a therapeutic alliance with these patients. Obstetrician–gynecologists should familiarize themselves with resources available through their local hospital, community, or state in order to appropriately and effectively refer patients for treatment. The core ethical purpose of routine screening for

substance use disorder is the beneficent provision of timely and effective care, rather than stigmatization or punishment. Physicians who identify alcohol use disorder, for example, may offer their patients alternatives to their continued drinking, including stopping drinking, cutting down on use, and seeking help. Brief intervention by physicians or peer educators has been shown to be as effective as conventional treatment for alcohol and substance use disorder and can produce dramatic reductions in use, improved health status for the patient, and reduced costs to society (8–14).

Nonmaleficence

The obligation to prevent, or not to impose, harms (nonmaleficence), including harms of omission, also is relevant to care for patients with substance use disorder. Medical care can be compromised if a physician is unaware of a patient's substance use disorder, which results in missed diagnoses, unexpected or dangerous medication interactions, or psychosocial harms. Patients also may be harmed when substance use disorder is viewed as a moral failing rather than a medical issue (15). Women with substance use disorder particularly are likely to be stigmatized and labeled as hopeless (16). Humiliation as a tool to force change is ethically and professionally inappropriate, engenders resistance, and acts as a barrier to successful treatment and recovery (16). As leaders of the health care team, it is important for physicians to model empathy and support rather than criticism when caring for patients with substance use disorder.

Justice

The principle of justice in medicine governs equitable access to care, fair distribution of resources, and nondiscriminatory medical practices. This principle requires that routine screening for substance use disorder should be applied equally to all people, regardless of age, sex, race, ethnicity, or socioeconomic status. Physicians may fail to apply principles of universal routine screening. When women are less likely to be screened or referred for treatment for substance use disorder, their burden of disability is increased and health status decreased. Another source of injustice is that punitive measures related to substance use disorder are not applied evenly across sex, race, and socioeconomic status. For example, in a landmark study among pregnant women who were anonymously tested for drug use, the prevalence of use was found to be similar between African American women and Caucasian women but African American women were 10 times more likely to be reported to law enforcement as a result of positive screening results (17). And, despite the significant involvement of male partners in perpetuating a pregnant woman's substance use disorder (18) and the implications of paternal substance use disorder on the functioning of the family unit, there has been no attempt to impose legal sanctions for paternal substance use disorder such as those imposed for pregnant women (19). Universal application of substance use disorder screening questions, brief intervention, and referral to treatment eliminates these disparities.

Justice also requires that preventive education and treatment referral should be provided for all patients in whom substance use disorder is identified. Experts at the National Institute on Drug Abuse confirm that substance use disorder is a "brain disease" with psychologic and physiologic manifestations and should be included in a medical review of systems consistent with that of any other biologic disease process (20). Failure to diagnose and treat substance use disorder with the same evidence-based approach applied to other chronic illnesses reduces a patient's access to health care services and resources. Just as with any chronic medical condition, physicians should counsel their patients with substance use disorder and refer them to an appropriate treatment resource when available, even if there might be a low likelihood of response to treatment. Obstetrician–gynecologists' knowledge of available community resources is critical for such patient education and referral.

Respect for Autonomy

Respect for autonomy directs that patients have the right to full information about their health and health care and the power to make their own health care decisions. A climate of respect and trust within the patient–physician relationship promotes patient autonomy and enables effective intervention for women with substance use disorder by increasing motivation to change, supporting self-efficacy, and offering hope and resources (21, 22). When a legal or medical obligation exists for obstetrician–gynecologists to test patients for substance use disorder, there is an ethical responsibility to notify patients of this testing and make a reasonable effort to obtain informed consent. Patients who fear sensitive information may be disclosed to others will be inhibited from honest reporting to their physicians (23). If a patient has the capacity to make her own decisions and declines to discuss alcohol and substance use, the physician should respect her decision. However, strong claims for public health concerns related to a patient's substance use may set limits on what that patient can refuse or choose (24). A significant ethical dilemma is created by state laws that require physicians to report the nonmedical use of controlled substances (drugs or other chemicals that are potentially addictive or habit forming) by a pregnant woman and laws that require toxicology tests of the woman, her newborn, or both after delivery when there is clinical suspicion for fetal exposure to potentially harmful controlled substances. Such laws may unwittingly result in pregnant women concealing substance use from their obstetricians or even forgoing prenatal care entirely. State lawmakers are encouraged to look to science-based guidelines, medical evidence, and ethical principles to guide appropriate public health interventions. The American Congress of Obstetricians and Gynecologists

has developed a tool kit for obstetrician–gynecologists and policy makers interested in optimizing autonomy and beneficence in state legislation related to pregnant women's use of licit or illicit substances (25, 26).

Ethical Approach to Common Patient-Care Issues Related to Substance Use Disorder

Obstetrician–gynecologists have a responsibility to respond in a medically and ethically appropriate manner, within legal requirements, to patient-care issues involving substance use disorder. Cornerstones of an ethical approach to the management of substance use disorder include patient education and safe prescribing practices; care and advocacy for patients with substance use disorder who are parents, pregnant, or seeking pregnancy; and protection of patient autonomy, confidentiality, and the integrity of the patient–physician relationship to the extent allowable by law.

Patient Education

Patient education is central to the prevention of intentional and unintentional therapeutic drug diversion, with a trusting relationship between physicians and their patients at the core of this education process. This relationship is especially vital when patients ask their physicians to prescribe medications that are not indicated. In partnership with local pharmacies, physicians also should be a resource for their patients regarding proper use, storage, and disposal of medications (4).

Safe Prescribing Practices

When treating patients with acute or chronic pain, obstetrician–gynecologists have an ethical responsibility to follow current best prescribing practices for controlled medications in order to avoid inadequate or inappropriate treatment of pain and patient misuse or diversion (ie, redistribution) of prescription medications such as opioids. It is inappropriate to avoid treating acute pain because of concerns for opioid addiction, although alternative and complementary pain relief modalities also should be considered. Obstetrician–gynecologists can be proactive in developing careful postoperative care plans for patients with a history of opioid use disorder. Consultation with pain specialists often is appropriate for patients at risk of opioid withdrawal and for patients with chronic pain syndromes who may be at risk of opioid dependence.

Reporting Substance Use in the Medical Record

Because of concerns regarding patient confidentiality, physicians may be reluctant to record information related to substance use or substance use disorder in patients' medical records. On the one hand, the physician may be concerned about nonmaleficence. Because medical records may not be safe from inappropriate or state-mandated disclosures of a positive drug test result or a diagnosis of substance use disorder, the patient may experience real harms—including job loss unrelated to workplace performance issues, eviction from public housing, loss of public assistance benefits, termination of insurance, arrest and incarceration, and removal of child custody. On the other hand, the principles of beneficence and nonmaleficence require that physicians ensure the accuracy of the medical record to optimize collaborative care with other clinicians. Pertinent medical information obtained by obstetrician–gynecologists may be vital for other clinicians to provide appropriate patient care and avoid harm. Concerns about breaching confidentiality and causing harms through disclosure can be appropriately addressed by including only accurate and medically necessary information in the medical record and informing the patient why and how this information will be included.

Maternal Substance Use Disorder

Fetal Exposure

Published evidence should guide physician concern for the fetal effects of any substance exposure. Although a full description of the multiple possible effects of alcohol on offspring cognition and behavior is beyond the scope of this document, the effect of alcohol use in pregnancy remains the best studied among prenatal substance exposures. There are few data linking maternal opioid use to fetal growth restriction or congenital anomalies; however, a transitory and treatable opioid withdrawal syndrome (neonatal abstinence syndrome) is well described, and may be seen in 55–94% of neonates with significant fetal exposure to opioids and more infrequently after exposure to a number of other substances (27–29). Although stimulants such as cocaine and methamphetamine have not been clearly linked to neonatal abstinence syndrome, intrauterine exposure to these agents has been associated with fetal growth restriction and adverse effects on infant neurobehavior (28, 29).

Biologic Testing

It is important to consider carefully whether biologic testing is needed when there is clinical suspicion of fetal exposure to potentially harmful substances. Although several maternal biologic specimens, neonatal biologic specimens, or both can be used to test for drug exposure, each has its limitations, and it is more likely that fetal exposure will be identified through a structured interview. In fact, routine testing of maternal or neonatal biologic specimens when a maternal history is positive for substance use disorder might increase medical costs without providing information that actually guides the care of the neonate (27–29). Despite suspicion of or a known history of substance use disorder, alternate diagnoses for any neonatal abnormalities should always be considered and appropriately investigated.

Conversely, unawareness of a maternal history of opioid use may lead to a failure to recognize the signs of withdrawal because many of these findings may be seen in other common neonatal problems such as sepsis or hypoglycemia, thus delaying timely care of neonatal abstinence syndrome. Clarifying whether and when a pregnant patient may have last used licit or illicit substances is best undertaken through respectful dialogue with that patient, focusing on benefits to her and her child. If an obstetrician suspects, based on screening, that there is an immediate risk to the neonate, there is an ethical obligation to communicate this suspicion to the patient and pediatrician.

Reporting Laws

Courts have long upheld a right to privacy, which includes the right to decide whether to have a child, the right to bodily integrity, and the right to "be let alone" (30). The U.S. Supreme Court also recognized the importance of privacy to the patient–physician relationship when it ruled in 2001 to prohibit a public hospital from using results from drug testing done for medical purposes to further a criminal investigation without a warrant or specific consent (31). This decision held that individual physicians could be held liable in such cases for participating in illegal searches that violate patients' constitutional rights.

Nevertheless, some state laws may compel physician reporting of a positive drug test result or suspicion of illicit drug use during pregnancy. As a result of judicial interpretation, some states now specifically authorize prosecutions of women who become pregnant and use controlled substances. Although one of these laws applies to women who continue their pregnancies to the point of viability, another state's law applies to women from the moment they become pregnant; as a result of judicial interpretation, this appears to permit arrest for the use of all controlled substances during pregnancy, including those prescribed to the pregnant woman (32). In addition, prosecutors have relied on existing criminal laws, such as general child abuse laws, to punish pregnant women for using a criminalized drug (33). State civil commitment laws may permit commitment of pregnant women who expose their fetuses to alcohol or other substances of abuse (34). States vary in the specific substances triggering such actions, as well as in the level of evidence required to report a case to the child welfare system.

Obstetrician–gynecologists should function as patient advocates and oppose coercive screening, testing, and treatment interventions and prosecution of a particular population for substance use disorder. Obstetrician–gynecologists should protect patient autonomy, confidentiality, and the integrity of the patient–physician relationship to the extent allowable by laws regarding disclosure of substance use disorder. Physicians should be aware that reporting mandates vary widely and be familiar with the legal requirements within their state or community. As previously noted, when a legal or medical obligation exists for physicians to test patients for substance use disorder, there is an ethical responsibility to notify patients of this testing and make a reasonable effort to obtain their informed consent. In states that mandate reporting, policy makers, legislators, and physicians should work together to retract punitive legislation and identify and implement evidence-based strategies outside the legal system to address the needs of women with addictions (35).

Treatment

Obstetrician–gynecologists should, when possible, advocate evidence-based and consensual interventions related to substance use disorder. Putting pregnant women in jail, where substances may be more available but treatment is not, jeopardizes the health of pregnant women and that of their existing and future children (33, 36, 37). Work being done on a state level to make treatment of substance use disorder more readily available to pregnant women has been bolstered by federal regulations requiring that pregnant women be provided with priority access to programs (38). Physicians are encouraged to continue to advocate the creation of treatment and rehabilitation centers that prioritize options for pregnant women, and it is hoped that policy makers, legislators, and physicians will work collaboratively to retract punitive legislation and identify evidence-based strategies outside of the legal system to improve treatment options and access for pregnant women with substance use disorder (26, 35).

Breastfeeding

Breastfeeding is important for maternal and infant health and bonding and provides an inexpensive and safe alternative to formula. For these reasons, a woman with a current or past history of substance use disorder should not be summarily excluded from or criminalized for nursing her infant. For women in well-supervised methadone-maintenance programs for treatment of opioid dependence, breastfeeding is encouraged and may be important to avoid neonatal abstinence syndrome (39). Obstetrician–gynecologists must have accurate information, however, regarding the potential dangers of transmission of illicit substances and high concentrations of alcohol through breast milk so that they can accurately advise their patients on the relative benefits or harms of breastfeeding (40).

Parental Substance Use Disorder

Obstetrician–gynecologists have an ethical responsibility to their pregnant and parenting patients with substance use disorder to discourage the separation of parents from their children solely based on substance use disorder, either suspected or confirmed. Despite this, many physicians support efforts to separate women with substance use disorder from their children. More than one half of physicians surveyed supported a statute that would permit removal of children from any woman who abused

alcohol or drugs (41). This position is especially concerning because these responding physicians did not require evidence of physical or emotional neglect or physical or sexual abuse in providing this survey response. Physician support of efforts to separate women with substance use disorder from their children most often reflects a desire to protect children, although some physicians also may feel that substance use disorder is a moral failing that deserves punishment. However, threats and incarceration have proved ineffective in reducing the incidence of substance use disorder.

Furthermore, removing children from the home not only violates child welfare goals of family integrity, but actually may subject children to greater risks in the foster care or child welfare systems (42). Treatment of substance use disorder is more effective and less expensive than restrictive policies (43) and results in a net medical savings per mother–infant pair (44). Women who have custody of their children during treatment of substance use disorder also complete treatment at a higher rate than women whose children are taken from them (45, 46).

Parental substance use disorder does not necessarily result in child harm or neglect. Nevertheless, when there is strong evidence of harm to children that is due to parental substance use disorder, obstetrician–gynecologists have an ethical obligation, along with their pediatrician colleagues, to engage child protective services to more fully assess risk of child harm. Each case should be evaluated independently and fairly, and available services should focus on maintaining or reunifying families rather than punishing and stigmatizing parents.

Infertile Patients With Substance Use Disorder

Obstetrician–gynecologists or other providers of infertility services may be faced with ethical dilemmas in which they must balance the interests of infertile patients with substance use disorder, the potential interests of future offspring, and their own conscientious practice interests (47). Although substance use disorder in a parent does not necessarily result in child neglect or inadequate parenting capacity, every effort should be made to identify and treat this disorder before conception in order to optimize maternal health and the health of future offspring. Any decision to decline to provide infertility treatment based on child safety concerns should be supported by clear evidence, made in conjunction with a multidisciplinary team of health care providers (47), and applied equally regardless of age, race, ethnicity, and socioeconomic status.

Adolescent Substance Use and Substance Use Disorder

Confidentiality is as important to the patient–physician relationship with adolescents as with adults, and physicians must build a relationship of trust with their adolescent patients in order to facilitate candid discussions regarding health-related behaviors that include the use of alcohol and other substances. Physicians should consider issues of informed consent, parental permission, and adolescent assent when dealing with detection and treatment of adolescent substance use disorder. Obstetrician–gynecologists should be aware of state laws that protect the confidentiality of minors regarding testing or treatment for substance use disorder. Minors, in general, may not be subjected to involuntary testing at their parents' request.

Physicians may discuss issues of confidentiality with the parents or guardians of their adolescent patients to encourage parental involvement in health care decisions and, when appropriate, facilitate communication between these parties. In that discussion, parents and adolescents may be counseled that the information shared between each of them and the physician is treated as confidential. Any restrictions on the confidential nature of the relationship would involve disclosure of risks to self or others (48).

Physician Personal Use of Medications and Illicit Substances

If obstetrician–gynecologists identify substance use disorder in themselves or their colleagues, they have an ethical responsibility to safeguard patients by modifying their own practice and by seeking guidance from professional organizations to assist with resources for support and intervention. Except in emergencies, it is never appropriate for physicians to write prescriptions for controlled substances for themselves or their family members (49). It is unethical for obstetrician–gynecologists to practice medicine with diminished capacity resulting from the use of alcohol or licit or illicit substances because it may put patients at risk of harm (50, 51). The American Medical Association's Code of Medical Ethics and the American College of Obstetricians and Gynecologists' Code of Professional Ethics also direct that physicians have an ethical obligation to respond to evidence of questionable conduct or impairment in colleagues that may be related to substance use disorder. Physicians are obligated to assist with timely intervention and identification of a local treatment program for these colleagues felt to be at risk of impairment; appropriate intervention often is directed by state or national professional organizations (51, 52). Physicians are obligated to cooperate with appropriate authorities who may be investigating unsafe behaviors and to report colleagues to local medical boards if "reasonable offers of assistance" and referral have been fruitless (53). Hospitals and state medical societies have similarly been empowered to identify physicians who may be impaired and to refer them for rehabilitation, with the future goal to return to their professional roles (54).

Conclusion

Incorporating the ethical frameworks presented in this Committee Opinion will help obstetrician–gynecologists

navigate difficult professional situations involving substance use disorder. These ethical frameworks support the routine screening of all patients for substance use disorder, and brief intervention and treatment referral for those patients with positive screening results. Obstetrician–gynecologists also have a responsibility to respond in a medically and ethically appropriate manner, within their local regulatory boundaries, to patient-care issues involving known or suspected substance use disorder. Maintenance of a therapeutic relationship will optimize care and advocacy for patients with substance use disorder who are parents, pregnant, or seeking pregnancy. It also is important to advocate patient autonomy and confidentiality in the face of legally mandated drug testing and reporting. Finally, it is good medical practice and ethically appropriate for obstetrician–gynecologists to ensure their safe prescribing practices for legal therapeutic drugs and to be vigilant against licit or illicit substance use disorder in themselves or their medical colleagues in order to optimize personal and patient wellness and safety.

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