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Exploring ethical dilemmas in the care of pregnant women in Ghana: a case of "maternal-foetal conflicts in a peri-urban hospital in Ghana"

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Abstract

Introduction Bioethics judgments often involve health care decisions, requiring careful consideration of rights, principles, beliefs, and interests. Maternal–foetal conflict presents ethical challenges regarding the balance between a mother's rights, the needs of the foetus, and medical treatment. The changing landscape of reproductive technologies and medical treatments requires a rethinking of existing ethical frameworks to ensure their relevance and adequacy in tackling new concerns.

Aim This study aims to fill these gaps by exploring midwives' perspectives on maternal–foetal conflicts in a peri-urban district hospital in Ghana, thus contributing to a context-sensitive understanding of maternal health ethics.

Methodology The study used an exploratory qualitative approach with in-depth interviews and focus group discussions. It involved twelve health professionals: ten midwives, one gynaecologist, and one quality assurance officer from a healthcare facility. We purposively recruited midwives who encountered conflicts between mothers' and babies' needs in their practice to share their experiences. We analyzed the data thematically to identify the moral, legal, and social issues related to these conflicts in peri-urban healthcare facilities.

Results The analysis identified four themes. First, there were tensions between maternal autonomy and foetal protection, as some women refused medically indicated procedures for personal or religious reasons, creating ethical dilemmas for clinicians. Second, cultural and religious beliefs strongly shaped treatment decisions, with refusals of caesarean section, blood transfusion, and other interventions occurring even when clinical risks were understood. Third, socioeconomic barriers limited access to essential care, raising concerns about fairness and equity. Finally healthcare providers reported moral distress and uncertainty due to community expectations and the absence of structured ethical guidelines. In such contexts, clinicians relied primarily on available clinical protocols, resulting in maternal autonomy being upheld only when it aligned with clinical judgement and perceived safety. Across themes, low educational status, strong religious influence, and cultural norms were key factors shaping decision-making

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and limiting women's understanding of medical risks, often prioritizing clinical judgement over expressed maternal preferences.

Conclusion Maternal-foetal conflicts are real in maternal health, affecting both clinical decision-making and clinical outcomes of pregnancy. Clear ethical and legal guidance on the status of the foetus is essential for resolving maternal-foetal conflict. The use of medical protocols to guide decision-making during such conflicts reveals a significant gap in patient-centred care. The study emphasizes the need for a structured ethical framework at both the hospital (local) and national levels. Ethics committees, medical councils, and professional associations must lead this charge of establishing these guidelines. Developing case-specific consent processes and including sociocultural perspectives in clinical practice would lead to a more balanced and ethically sound approach to managing these conflicts.

Trial registration Not Applicable.

Keywords Maternal-foetal conflict, Ethical guidelines, Dilemmas, Peri-urban, Informed consent, Maternal autonomy, Ghana

Background

Bioethics judgments often involve health care decisions, requiring careful consideration of rights, principles, beliefs, and interests. The beginning and end of life are particularly challenging for these decisions [1, 2]. Pregnant women have a unique relationship with their foetus, creating a unique biological, psychological, moral, and legal link. However, recent changes in maternal-foetal practice have altered the foetus's clinical state. Traditional methods for evaluating the foetus's health and development are difficult to directly examine, and the foetus cannot be examined while it is developing [3].

Doctors view pregnant women and their foetus as one patient, however, with advances in medical imaging and in-utero interventions, the foetus is now increasingly regarded as a distinct patient [4, 5].

High-definition ultrasound imaging and tissue and blood collection methods in foetuses have revolutionized mother-foetus interactions, allowing clinicians to observe unique anatomy, physiology, and biochemistry [6]. Medical and surgical techniques used in utero are now offering replacements for medicinal delivery and newborn care when abnormalities are found. The biological bond between a mother and her unborn child has not altered, but the connection is now viewed as duality rather than unity [1]. Doctors now focus on the foetal organism as a distinct patient, leading to new ethical, social, and legal ramifications. In situations where the welfare of the mother and the unborn child conflict is of particular concern, physicians and society often have the duty to advance either party's welfare or make a decision [1, 6].

Maternal-foetal conflict occurs when a pregnant woman's interests conflict with the interests of the foetus, as determined by her doctor [6]. Legal and ethical considerations have become more complicated with advances in medicine and technology. Some cases involve the law, but most doctors avoid it [7]. The severity of the conflict depends on whether the woman and the foetus have distinct interests and rights that deserve respect [1]. Conflicts can arise when a pregnant woman chooses not to follow medical advice, such as blood transfusions, foetal surgery, or cesarean deliveries, or if she smokes, consumes alcohol, uses drugs, or works in dangerous settings [1, 4, 5]. The struggle intensifies as the woman or foetus nears term or viability, as more defences of the foetus' legal and moral standing are made [2].

Mother-foetal conflict presents ethical dilemmas involving maternal autonomy, foetal rights, and medical decision-making. With medical advances, the balance between mother autonomy and preserving foetal welfare becomes more complex, affecting healthcare professionals and legislators. When left unresolved, these conflicts can lead to significant consequences. For mothers, they may result in violations of autonomy, psychological distress, or preventable morbidity and mortality [8, 9]. For foetuses, delayed or denied interventions can lead to adverse outcomes such as stillbirth or long-term disabilities [8]. Healthcare providers are also impacted, as ongoing conflicts can create moral distress, legal ambiguity, and challenges in maintaining trust with patients and their families [10, 11]. Therefore, maternal-foetal conflict emerges not only as a clinical and ethical concern but also as a public health and policy issue with far-reaching implications [8].

Available evidence lacks a thorough examination of the ethical dilemmas inherent in maternal-foetal conflict in Ghana, and there is an urgent need to investigate how these dilemmas appear in various medical, cultural, and socioeconomic circumstances. Furthermore, the changing landscape of reproductive technologies and medical treatments needs a rethinking of existing ethical frameworks to ensure their relevance and sufficiency in tackling new concerns.

This study sought to critically examine the ethical dilemmas inherent in maternal-foetal conflict, taking into account aspects such as medical breakthroughs, cultural differences, and legal frameworks. The study's goal was to examine ethical conflicts, consensus points, and

prospective areas for ethical standards improvement by looking at the opinions of healthcare professionals. The findings will contribute towards creating nuanced, morally sound methods to resolving maternal-foetal disputes, promoting a greater understanding of the delicate balance necessary to manage these complex ethical dilemmas responsibly and compassionately.

Methods

Study design

The study employed an exploratory qualitative research approach, as maternal–foetal conflict is a complex, context-dependent phenomenon that cannot be adequately captured through quantitative measures alone. Ethical dilemmas in this area often encompass deeply personal values, cultural beliefs, and professional judgments, necessitating an exploration of lived experiences rather than reliance on numerical data. To investigate the moral, legal, and social challenges associated with maternal-foetal conflict situations in Ghana, the study utilized focus group discussions and in-depth interviews.

Study setting and population

Participants in this study were health service providers in a hospital in a peri-urban area in Ghana. These service providers included midwives and gynaecologists from the hospital, who had experienced maternal-foetal conflict situations. The facility reported 4,594 deliveries in 2021, 4593 deliveries, 1 maternal death, and 2409 mid-year deliveries in 2022, 11 maternal-foetal conflict situations with 7 resolved, 3 maternal deaths, and 1 was referred to a higher health facility.

Sampling

Purposive sampling was used to select participants from the hospital's maternity and labour ward who were health workers who had experienced maternal-foetal conflict situations between 2022 and 2023, ensuring diverse perspectives on ethical, legal, and social decision-making approaches.

Data collection techniques and tools

Twelve [11] health professionals (ten midwives, one gynaecologist, and one quality assurance officer (a non-clinical professional who ensures that patient care and hospital processes consistently meet required safety, quality, and regulatory standards)) were purposively selected for their relevant experience. Participants varied in age, professional background, and years of experience, offering diverse perspectives on these conflicts.

Data were collected through twelve face-to-face in-depth interviews (IDIs) lasting 45 to 50 min and two focus group discussions (FGDs) with a minimum of five participants each, lasting 90 to 100 min. The interview and discussion guides were tailored to the local context and explored the ethical, legal, and social implications of maternal–foetal conflicts, including healthcare providers' decision-making processes. Two case scenarios were used in the FGDs to stimulate discussion. Interviews were conducted in English, Twi, and Ga, audio-recorded, and translated by trained personnel. Interviewers were trained on the guides, which were pretested at a teaching hospital in Ghana to ensure clarity.

Data collection continued until saturation was reached. This saturation was confirmed by consistently reporting recurring themes related to the moral, legal, and social challenges involved in maternal-foetal conflicts.

Data handling and analysis

All audio recordings from IDIs and FGDs were transcribed verbatim and checked for accuracy before being imported into NVivo 12 for coding and analysis. A narrative inductive approach was used to explore participants' accounts, with a focus on ethical decision-making processes in maternal–foetal conflicts.

Data were analyzed using thematic content analysis, allowing large volumes of textual information to be systematically organized into codes, categories, and themes. Coding was conducted independently by the lead investigator and a field assistant, followed by consensus meetings to resolve discrepancies and ensure reliability. The analysis focused on their knowledge, challenges, ethical principles guiding decision-making and the factors influencing healthcare practitioners' responses to maternal–foetal conflicts. Results were illustrated using direct participant quotes to enhance authenticity and contextual understanding.

To enhance trustworthiness and credibility, we elicited triangulation using both in-depth interviews (IDIs) and focus group discussions (FGDs). Transferability was achieved by providing detailed descriptions of the study context and processes, allowing readers to assess applicability. Dependability was ensured through an audit trail of coding decisions and data management, while confirmability was maintained via reflective journaling and peer debriefing to accurately capture participants' perspectives.

A total of four main themes and thirteen sub-themes emerged, reflecting the moral, legal, and social challenges faced by healthcare providers, including barriers related to education, religious beliefs, cultural norms, and institutional factors.

Ethical approval and consent to participate

Ethics approval was obtained from the Institutional Review Board, with ethics approval number DHRCIRB/209/10/22. Participants provided informed consent, ensuring their data remained confidential and

Table 1 Study participant category

Category of Participants	Data Collection Method	Data Collection Guide
Midwives	In-depth Interviews and FGD	Interview Guide and Case Scenarios
Medical officers/ maternal-foetalian specialist and Facility Manager	In-depth Interviews and case scenario FGDs	Interview Guide
Pregnant woman and/or a client with a maternal-foetal conflict where possible	In-depth Interview	Interview Guide

anonymous. We shared clear study information and allowed time for questions. Participants provided verbal consent. We assigned ID numbers to protect identities and secured data with passwords. Participants could withdraw at any time without penalty. While there are minimal risks, the findings may aid maternal and foetal decision-making. Participation is voluntary and will not affect medical care.

Reflexivity

The first author (ZH) is a public health nutritionist and bioethicist with extensive experience in maternal and child health, ethics review, and health systems administration in Ghana. He has served as a municipal nutrition officer, district-led supporting nutrition programmes, and as an administrator and reviewer for an institutional review board. His training in bioethics shaped his sensitivity to ethical dilemmas in maternal–foetal care and the rights of vulnerable populations.

This professional background may have influenced both the framing of the research questions and the interpretation of the midwives' accounts, particularly in recognizing tensions between medical imperatives and maternal autonomy. At the same time, familiarity with Ghana's health system and clinical practices facilitated rapport with participants and allowed deeper contextual understanding of their perspectives. To minimize bias, findings were discussed with colleagues in ethics and maternal health, and interpretations were grounded in participants' narratives rather than the researcher's prior assumptions.

Results

Background of study participants

The study involved twelve health workers, including ten midwives, a gynaecologist, and a quality assurance officer tasked with ensuring adherence to best practices within the facility. Most participants were women, aged 28 to 45, with tertiary education and experience working in hospitals for a duration of 3 to 10 years. Table 1 provides information on categories of participants while Table 2 provides information of the background of study participants.

Table 2 Demographic characteristics of respondents

Variables	Total number of Respondents (*N* = 12)
Sex	
Male	2
Female	10
Age group (Years)	
28–39	11
40–45	1
Category of Health Personnel	
Midwives	10
Quality Assurance Officer	1
Obstetrician & Gynaecologist	1
Number of Years served	
1–5	8
6–10	4
Level of Education	
Tertiary	12
Number of Maternal-foetal Conflicts	
Recorded	11
Resolved	7
Referred	1
Unresolved (Death)	3

The study found four main themes that show the ethical problems in situations where the mother and baby might have conflicting needs. First, there were conflicts between a mother's right to make her own choices and the need to protect the baby. This was seen when some women refused necessary medical treatments like cesarean sections for personal or religious reasons. Second, cultural and religious beliefs heavily influenced the decisions women made. Some chose not to have cesarean sections or blood transfusions and avoided therapeutic abortions because their beliefs went against medical advice. Third, financial difficulties created more challenges. Many women couldn't afford important vaccines and treatments, raising concerns about fairness in healthcare access.

Lastly, healthcare providers faced issues at work, experiencing moral distress when they had to balance what the community expected with medical ethics and dealing with unclear or weak hospital policies. The themes and subthemes show how beliefs, culture, social inequality, and professional duty come together to create ethical issues in maternal and foetal care. Table 3 in the appendix gives details of the themes and subthemes that emerged. Table 3 describes the various themes, subthemes and their corresponding maternal-foetal conflict situations.

Table 3 Types of maternal-foetal conflict situation

Maternal-foetal conflict	Summary situation
Refusal of CS due to the religious leader's advice	A 23-week-old first-time mother presented to the labour ward with pregnancy-induced hypertension and proteinuria, both of which have grave and fatal repercussions for both the mother and the foetus. The medical team chose to perform a CS, but the mother refused to have it done since, according to her religious leader, she would die if she went through with it
Refusal of blood transfusion due to religious belief	A pregnant woman of Jehovah's Witness faith who was anaemic arrived at the labour ward and required a blood transfusion during delivery. The woman and her husband were informed of the development, but they submitted a card from their church (power of attorney) saying they would not accept blood transfusions that could save the mother's and the foetus lives.
Refusal of surgical procedure due to maternal personal reasons	A pregnant woman who is bleeding heavily from the vagina arrived at the clinic and requires surgery because the baby's heart was still beating when she arrived. But for reasons that are best known to her, she chooses not to have the procedure.
Inability of a mother to take vaccines due to financial challenges	A pregnant woman with a known hepatitis B which can infect her baby, is told to get a vaccine and immunoglobulins. But she says she cannot afford it, and more so, she has had that condition during her previous births without a vaccine, and the children did not get infected.
Caesarean section	The case of a pregnant woman with prolonged labour and a distressed baby was informed of the need for CS to save the baby and mother. The husband and family believed that their wife could deliver virginally, as proclaimed by their religious leaders. The family insisted that if their pastor did not give permission and the CS was done, their wife could die.
Refusal to conduct an abortion due to cultural reasons	A woman with an ectopic pregnancy and problems was reported to the maternity department. The medical staff, upon assessment, asked that a surgical intervention be performed quickly to terminate the pregnancy and save the mother's life. Despite being made aware of the scenario, the mother and family are refusing to allow the team to continue with the course of therapy because they feel it is taboo to terminate the life of an innocent child.

Knowledge of maternal-foetal conflicts

According to the majority of the midwives who participated in the in-depth interview, maternal-foetal conflicts arise when a mother's (maternal) aspirations contradict the safety of the foetus, and when a mother refuses a mode of treatment, which would be beneficial for both the mother and the foetus. Table 4 describes some listed maternal-foetal conflicts that arise.

> *"When a Caesarean section (CS) is needed during a prolonged labour with a distressed baby, but the mother refuses because of her religious convictions, a maternal-foetal conflict arises." (IDIR2-midwife).*
> *"When a pregnant woman needs urgent medical care that can save both her foetus and her life, but she does not agree with their medical assessment based on her own readings online" (IDIR4-midwife).*
> *"Maternal-foetal disagreements arise when pregnant women are engaged in activities like smoking or drinking that could harm the development of the foetus." (IDIR7midwife).*

Challenges and factors associated with maternal-foetal issues

The study identified several key factors contributing to maternal–foetal conflicts, with maternal autonomy, educational status, cultural norms, and religious beliefs emerging as the most influential.

Midwives reported that a woman's level of education significantly influenced her acceptance or rejection of recommended medical interventions. Women with lower literacy levels were generally more receptive to guidance from healthcare professionals. In contrast, women with higher educational status often conducted independent research via the internet or consulted other medical platforms before making decisions, sometimes prioritizing these sources over professional advice.

> *"Some women believe they know everything because of their educational background. Most of the time, the more educated women who arrive at the labour ward with complications are the ones who are the hardest to treat, so when you explain what needs to be done, they assume that because they are educated, they will rather consult the internet for answers than pay attention to the midwives who are caring for them." (IDIR6-midwife).*

Religious convictions were highlighted as a major factor affecting women's choices, with some women refusing interventions that conflicted with their beliefs.

> *"Some of the women who visit the hospital are from strong religious families and place more faith in their pastors and prophets than the midwives who are taking care of them. Often, the women say that their pastor advised them not to accept a particular treatment. This is due to their regard for and conviction that their pastor is always right, which conflicts with the medical position at that time." (IDIR3-midwife).*
> *"The resolution of the maternal-foetal conflict issue is threatened by these pastors and prophets. Even though we are all Christians and believers in God, there are instances when you are trying to save a pregnant woman's medical predicament, and then pastors come with promises and prophesy regarding the condition that is parallel to the medical procedure needed." (FGDR2-midwife).*

Table 4 Thematic framework from midwives' perspectives on Maternal–Foetal conflict

Themes	Subthemes	Illustrative Points/Description
Conflicts Between Maternal Autonomy and Foetal Protection	Maternal refusal of caesarean section based on religious authority	Participants reported instances where pregnant women refused medically indicated cesarean sections based on the advice of religious leaders, even in emergencies. This situation posed ethical dilemmas for clinicians, as respecting maternal autonomy could jeopardize foetal viability.
	Refusal of surgical intervention for personal or non-medical reasons	Some women refused surgery for non-religious reasons, such as fear of operative risks, distrust in the healthcare system, and worries about marital implications. These choices led to conflicts, especially as delays heightened risks for both the mother and foetus.
	Tension between respecting maternal choice and the clinician's duty to protect the foetus	Respondents expressed the tension between informed consent and professional responsibilities, particularly in cases where maternal decisions posed risks to the foetus, leading to moral distress and ambiguity regarding the limits of clinical persuasion.
	Ambiguity in determining acceptable limits of maternal autonomy during emergencies	Data indicated ongoing uncertainty regarding clinicians' ability to override maternal refusal in urgent obstetric emergencies. Participants emphasized a lack of clear institutional guidelines, exacerbating ethical ambiguity.
Religious and Cultural Influences on Critical Medical Decisions	Refusal of caesarean section due to the religious leader's advice	Respondents identified religious figures as primary decision-makers, with women frequently valuing spiritual authority over medical advice, resulting in delayed healthcare access. This trend was especially evident in communities with strong charismatic or prophetic traditions.
	Refusal of blood transfusion due to religious doctrine	Clinicians often encounter instances where women refuse blood transfusions during severe haemorrhage, framing their decisions as rooted in faith rather than a misunderstanding of associated risks. This situation creates an ethical dilemma for healthcare providers, balancing the respect for personal beliefs with the imperative to prevent harm.
	Clinician distress when cultural norms oppose evidence-based interventions	Respondents noted that cultural values, such as prohibitions against male clinicians treating married women, hindered urgent procedures. These norms delayed decision-making, compromised timely care, and created tension between clinical judgment and sociocultural expectations.
	Cultural objections to abortion despite clinical indications	Participants indicated that, despite medical justification for therapeutic abortion, cultural prohibitions hindered women's acceptance of the procedure. Clinicians noted the ethical dilemma of counselling women whose cultural beliefs categorically oppose termination, even when maternal health is endangered.
Socioeconomic Barriers and Unequal Access to Essential Care	Inability to accept recommended vaccines due to financial constraints	Some women encountered financial barriers to receiving recommended vaccinations, which respondents viewed as ethically distinct from religious or cultural objections. These barriers were attributed to systemic inequities rather than individual choices.
	Ethical tension between maternal resource limitations and foetal health needs	Participants highlighted the distress associated with adverse foetal outcomes resulting from poverty-related care delays. Clinicians regarded these situations as ethically problematic, as financial constraints limited care options, thereby undermining both patient autonomy and beneficence.
	Equity concerns where life-saving interventions are inaccessible	Respondents highlighted that, delays in essential interventions, such as emergency obstetric surgery and transfusion, often stemmed from financial constraints in procuring necessary supplies. These inequities led to preventable maternal-foetal harm and underscored systemic ethical failures within the healthcare system.
Professional Obligations and Institutional Constraints	Moral distress among clinicians when maternal or community expectations conflict with clinical ethics	Participants experienced emotional fatigue, frustration, and moral distress when required to adhere to decisions they perceived as detrimental to foetal or maternal outcomes. Constraints imposed by religious, cultural, or financial barriers exacerbated their ethical conflicts.
	Institutional challenges in enforcing standards of care while respecting diversity	Respondents highlighted inconsistent institutional policies surrounding maternal refusal, emergency decision-making, and religious objections. The absence of unified frameworks for reconciling autonomy, cultural sensitivity, and foetal protection resulted in uncertainty, exposing clinicians to potential blame, litigation concerns, and variable decision-making practices.

Cultural norms also played a role, as many women considered the opinions of spouses, family members, or religious leaders when making decisions about their care. These factors sometimes created tension between respecting maternal autonomy and ensuring foetal welfare, forming the core of maternal–foetal conflicts observed in the facility.

> *"When you describe the necessary treatment care for a woman who is in labour with problems. She will request you consult her husband because tradition mandates that a man make all decisions. Occasionally, the woman may hint that she is uncomfortable with her husband's decisions when they don't sit well with her, but she never challenges them out of fear." (IDIR5-midwife).*

Overall, the findings illustrate that maternal–foetal conflicts are shaped by a complex interplay of personal, social, and cultural factors, which influence ethical decision-making and clinical outcomes.

Guidelines for addressing maternal-foetal conflicts

We found that there are no standard guidelines (national and facility level) for managing maternal and foetal

conflicts. From the engagements, the healthcare workers agreed that the doctor determines what is in the best interest of the mother and foetus, but the woman makes the final decision.

> *"We always try as a hospital to respect the beliefs of your clients when rendering services to them. This is because when something goes wrong during the treatment, the family could sue the health professionals and the hospital. We provide information to all parties involved (husband and pastor) and get their support. Most of these cases lead to the breakdown of marriages, which has a social implication on the woman and family at large." (FGDR5-midwife).*

Where necessary, other professionals such as psychiatrists are consulted.

> *"In most maternal-foetal cases, we bring in a psychiatrist to assess the woman's mental capacity for soundness, and always they do not find anything wrong with their ability to make informed decisions" (FGDR1-midwife).*
> *"We always follow the treatment guidelines because they are designed to ensure that every decision, we make serves the best interest of both the mother and the baby." (FGDR5-midwife).*

They, as health workers, provide advice based on the situation. We found that, despite the absence of structured guidelines for resolving maternal-foetal conflict situations at the hospital, they refer to the hospital's standard operating procedures and standard treatment guidelines for making decisions [12–14].

The midwives and quality assurance officer indicated that the right to life and health is guaranteed under Ghana's 1992 Constitution under Article 13 and Article 34, respectively, which serves as the legal basis for reproductive health and maternity care.

Article 13 clause 1:*" No person shall be deprived of his life intentionally except in the exercise of the execution of a sentence of a court in respect of a criminal offence under the laws of Ghana of which he has been convicted."*

Article 34 of the Constitution of Ghana (1992) provides: *"The State shall take appropriate measures to protect the health of the people and ensure that medical care is accessible to all."*

> *"Most of the time, it takes a while to find a solution, especially in situations where you have to choose to save one. You want to save the mother because saving the unborn requires compromising the life of the mother. All officers required to make the decision are usually brought on board to assist in the decision-making. At that point, whether the woman agrees with it or not, the law requires us to save the mother and let the foetus go." (IDIR3-midwife).*

Clinicians' decision versus maternal autonomy

The midwives stressed that a health professional has the right to override a woman's decision if it will harm the woman herself. Also, they indicated that when a woman is delirious and no one else is available to make decisions for her, the physician is expected to act in her best interest.

> *"The law gives the clinician the right to overrule the patient whenever the decision made by the patient will not help the mother or the unborn child. So, in case when the woman is delirious and can't make decisions for herself or when there is no next of kin to make the decision, the clinician is mandated to make the decision he/she deems right for both the mother and unborn child" (FGDR1).*

Further discussions during the focus group discussion of the case scenario revealed that most doctors and midwives will refer to the treatment guide and disregard either parent's consent or decision in favour of making the choice they believe to be right, even though these choices frequently have the potential to violate the mother's autonomy, the foetus's right to life, or both parties' rights to justice, Sometimes, one of them may even suffer harm.

These decisions often have repercussions on the family and healthcare systems. Participants reported that decisions which appeared to override or limit maternal autonomy were often framed as necessary to protect the well-being of both the mother and the foetus. Some midwives expressed confidence that families would eventually understand and accept such decisions. One midwife stated,

> *"The family will, in time, come to appreciate that the decisions we made were the right ones."(FGDR4-midwife).*

Another participant emphasized that these actions were driven by the broader aim of reducing maternal mortality, noting that;

> *"We do it to help achieve the goal of lowering maternal deaths."(FGDR1-midwife).*

Participants also referred to institutional and legal guidance that requires weighing the protection of life for both mother and foetus, which they interpreted as supporting

interventions made in cases of imminent harm. In circumstances where the woman was unable to provide consent, decisions were reported to be made by the next of kin or a person acting *in loco parentis*, in accordance with facility protocols. These accounts reflect a practice context in which clinical judgement and perceived responsibility to preserve life shaped decision-making processes during obstetric emergencies.

The in-depth interviews (IDIs) and focus group discussions (FGDs) revealed a nuanced understanding of maternal–foetal conflicts. Clinicians consistently emphasized the importance of maternal autonomy, privacy, and informed consent, but these rights were sometimes constrained by a perceived duty to protect both the mother and the foetus. Healthcare providers reported that they sought to obtain consent whenever possible; however, when a woman's choices posed significant risk, the health of the mother and the survival of the foetus took precedence. In this context, maternal autonomy was respected primarily when it aligned with medical assessments and prognosis. Overall, informed consent remained a fundamental principle, but it was not always the decisive factor in care decisions.

> *"We will always follow the woman's decision regardless of what the husband says when the woman arrives at the hospital, provided that she is not mentally ill, awake, and capable of making decisions." (IDI9-gynaecologist).*
> *"In terms of strength and pain tolerance, women are highly strong. Rarely, unless the mother already has a mental illness, have I observed cases where a woman's mental capacity was impacted by birthing pain. A woman's capacity to make an informed decision is therefore unaffected by any amount of suffering she endures." (FGDR3-midwife).*

The study also revealed that in circumstances where the woman is incompetent or when her decision endangers the unborn child, the husband or guardian and religious authorities are consulted.

Additionally, they admitted that there were moments when they had to consider the man's judgment over the woman. Such occasions occur when the woman selects the man to make the decision orally or in writing, or when the woman is mentally ill or not sane enough to make the decision. But when a man's decision negatively affects both the mother and the unborn child, the facility refers the matter to the hospital management committee for resolution. If they are unable to do so, legal action is taken, and the law determines the appropriate steps.

The following are some explanations as to why the mother's autonomy might not be respected:

> *"If the woman is not sane or is mentally unstable, we rely on the man to make the decision. However, if the husband makes a decision that is not in the best interest of either the mother or the child, we refer the matter to the hospital authorities or pursue legal action to have a decision made." (FGDR2-midwife).*
> *"Sometimes the woman agrees that the husband should make all decisions as soon as they arrive at the hospital. Most of these cases are driven by cultural or religious reasons, but once she states that to the medical team, we will always consult the husband when making decisions about treatment procedures." (FGDR7-midwife).*

Foetal status issues

In terms of issues related to foetal status, all of the midwives who were interviewed agreed that a foetus is given a live status at 28 weeks. As a result, if there are any problems, in instances where the gestational age of the foetus is beyond 28 weeks, we implement medical procedures aimed at preserving foetal viability. Should the facility lack the necessary resources or expertise to manage the condition effectively, the patient is referred to a suitable medical centre for further care. Generally, although all efforts are made to save the baby, when there are conflicts and only one can be saved, the care providers agreed that their preference is to save the mother first.

> *"In our facility, when a foetus reaches 28 weeks, we start treating it like a person and consider it to be living. In general, we try to explain problems or complications to patients and do everything we can to rescue the foetus, even if it is 20 weeks old." (IDI1-midwife).*
> *"Even though the foetus is made a priority and considered during decision-making, at any point in time if it poses a risk or harm to the life of the mother, we will save the mother at the risk of the foetus, and even the law gives us that right to do that" (FGDR5-midwife).*
> *"Sometimes the family will say the baby is already a full human from the moment the woman misses her period. But in the clinic, we follow the medical guidelines. We look at viability. So yes, sometimes our understanding does not match theirs."(FGDR3-midwife).*
> *""Honestly, this issue brings a lot of conflict. Sometimes the family insists that we must save the baby at all costs, even when the mother is at risk. In those situations, we have to explain that our primary duty is to the mother. It can create tension, but our training is clear, and the law guides us to prioritize the mother when continuing the pregnancy would cause serious harm to her." (FGDR6-midwife).*

Discussion

This discussion focuses on complex maternal-foetal conflict situations identified in the study, analyzing how educational level, religious and cultural beliefs, and socioeconomic factors influence decision-making in obstetric care. The findings are evaluated against existing guidelines for managing these conflicts, which emphasize the balance between clinician responsibilities and patient rights, the application of maternal autonomy, and the conditions under which the foetus is given moral or clinical consideration. Using established ethical frameworks, particularly the principles of autonomy, beneficence, non-maleficence, and justice by Beauchamp and Childress, alongside the WHO's approach to respectful and culturally sensitive maternal care, illustrates how these dilemmas reflect larger issues in ethical governance, health system structures, and community norms. This framework sets the stage for discussing ethical management of maternal-foetal conflicts in contexts with limited resources and diverse cultural backgrounds.

Knowledge of maternal-foetal conflict situations

Maternal–foetal conflict has broad implications for families and society, particularly in Ghana, where reproduction is deeply tied to religious and cultural expectations within marriage [12]. Such conflicts occur when maternml decisions threaten foetal well-being, raising ethical dilemmas regarding maternal autonomy and safety. Examples include abortion, assisted reproduction, selective reduction in multiple pregnancies, treatment for foetal abnormalities, substance use during pregnancy, and non-compliance with medical advice [13–15].

Midwives in this study described maternal–foetal conflict as situations where women declined clinically indicated interventions for maternal or foetal health. Examples included refusal of caesarean section despite foetal distress, often linked to religious beliefs or reliance on alternative information, and challenging medical advice. These findings echo broader literature highlighting tensions between respecting women's autonomy and fulfilling clinicians' perceived duty to protect the foetus [16–19].

Participants also identified maternal behaviours, such as alcohol or tobacco use during pregnancy, as forms of conflict. While global debates caution that framing such behaviours as maternal–foetal conflict may undermine women's autonomy, they nevertheless raise genuine public health concerns [17, 18]. In African contexts, sociocultural and religious values further shape both provider perceptions and maternal decision-making, underscoring the ethical complexity of maternity care [18, 20, 21].

Overall, the midwives' perspectives reveal an emphasis on clinical responsibility for foetal well-being, tempered by recognition of maternal agency. This balance reflects ongoing negotiations between autonomy, beneficence, and duty of care in Ghana's maternal health system, where legal provisions, cultural norms, and health system constraints converge [18, 20, 21]; Ministry of Health, Ghana, 2014). Addressing these dilemmas requires clearer institutional guidance and ethics support structures to aid providers in navigating conflicts.

Finally, evidence suggests that structured interventions to address maternal–foetal disputes not only improve neonatal outcomes but also empower women to make informed decisions regarding their care [22, 23]. Supporting midwives with ethical tools and communication strategies may therefore enhance both maternal and foetal health while safeguarding autonomy.

Challenges in managing maternal-foetal conflicts

Balancing maternal and foetal rights

Balancing the rights of the mother and the foetus is a major ethical challenge worldwide. Globally, the American College of Obstetricians and Gynaecologists (ACOG) advises that obstetricians should not carry out procedures a pregnant woman refuses, and that courts should rarely be used to settle these conflicts [24, 25]. Still, debates continue: while some argue that the foetus has rights, especially after viability, when it could live outside the womb [26, 27]. Others warn that limiting women's autonomy reduces them to "baby-making machines" and threatens their basic civil rights [26, 27].

In Africa, ethical and legal debates are shaped by cultural and religious values. Many communities view the foetus as a person from conception, or in the second trimester of pregnancy, making maternal–foetal conflicts particularly sensitive [28, 29]. Legally, the Maputo Protocol under the African Charter on Human and Peoples' Rights protects women's reproductive health, including access to abortion in certain cases. Yet, many African countries still maintain restrictive laws, leaving health workers with little clear guidance when maternal autonomy and foetal interests clash [29].

Overall, from the global to the Ghanaian context, balancing maternal autonomy with foetal interests requires case-by-case ethical judgment, informed by law, culture, and medical realities.

Cultural and religious beliefs

Culture and religion remain powerful influences in maternal health decision-making in Ghana, where traditional and religious beliefs often shape maternal–foetal choices and may conflict with medical advice [22, 30–32]. Women may decline interventions such as caesarean section or abortion on religious or cultural grounds, invoking autonomy, while providers must balance this with their duty to protect maternal and foetal health [4, 6, 17, 18]. Providers' own beliefs can also shape responses, at

times causing moral distress when personal values conflict with professional obligations [18, 33, 34].

Findings from the peri-urban facility indicate that cultural and religious norms strongly influence maternal care-seeking in Ghana, reflecting broader sociocultural pressures [15, 32, 35]. Legally, the Ghanaian system prioritizes maternal life and health, allowing clinicians to override family wishes or religious objections in emergencies, as outlined in the Criminal Offences Act of 1960 (Act 29) [23, 36]. This creates ethical tension: providers must balance respect for maternal autonomy with their duty to preserve maternal and foetal life, generating profound moral dilemmas.

Education further shapes decision-making; women with higher education levels are more likely to question clinical advice or seek alternative information, while less-educated women more readily accept interventions such as caesarean Sects [37–40]. Together, these findings highlight the intersection of culture, religion, and education in shaping maternal autonomy and healthcare interactions.

For providers, navigating maternal–foetal conflict in Ghana requires sensitivity to religious and cultural values, awareness of legal frameworks, and attention to the influence of maternal education. Strengthening communication, counselling, and ethics support systems is essential to empower women to make informed choices while ensuring maternal safety and minimizing provider moral distress [41, 42]. Culturally responsive ethics training and institutional guidance could improve decision-making processes and maternal health outcomes [43, 44].

Ethical guidelines

This study underscores the absence of clear ethical guidelines for managing maternal–foetal conflicts in Ghana, compelling midwives to rely on personal discretion when navigating informed consent dilemmas. While clinical protocols exist, they do not address moral dimensions of care, leaving providers vulnerable to inconsistencies and moral distress [34]. Such discretion-based decision-making risks compromising maternal autonomy and foetal welfare, particularly where religious, cultural, and familial influences strongly shape women's choices [1, 45].

Evidence from other African countries highlights a similar need for structured ethical guidance. In Nigeria, reliance on cultural authority figures can undermine maternal decision-making, while in Uganda and Ethiopia, the absence of ethical standards contributes to inconsistent responses in life-threatening maternal–foetal situations [43, 46]. These parallels suggest that Ghana's challenges reflect a broader regional gap in ethics-based maternal health policy. Globally, established ethical frameworks help clinicians balance maternal rights with foetal interests. Ethical guidelines offer a structured approach for morally defensible decisions, reducing reliance on coercion or paternalism [46–48]. whereas interventions without ethical safeguards risk infringing on women's liberty or disproportionately affecting marginalized groups [14, 49, 50].

The findings indicate an urgent need for policies that go beyond clinical protocols to integrate ethical guidance, explicitly balancing maternal autonomy, beneficence, and foetal considerations. International frameworks, such as FIGO's, emphasize respect, compassion, and avoidance of coercion [16]. Adapting such frameworks to Ghana's sociocultural and legal context could provide midwives with a consistent ethical compass, reduce moral distress, and strengthen the balance between maternal rights and foetal welfare, offering insights relevant to other low- and middle-income countries facing similar challenges.

Clinicians versus maternal-foetal benefit

The principles of beneficence and utilitarianism dictate that healthcare professionals should prioritize actions that yield greater benefits than harms for patients [47]. Physicians are tasked with recommending treatment options that maximize health benefits while considering associated costs. In making these critical decisions, they must prioritize patient needs over their own and other stakeholders' interests [6].

These findings reveal a complex ethical tension in maternal–foetal care, where clinicians must weigh respect for the pregnant woman's autonomy against perceived obligations of beneficence toward the foetus. Within a principlist framework, the clinician's duty to uphold the woman's right to make informed decisions may conflict with professional commitments to prevent harm and promote foetal welfare [51, 52]. However, the application of autonomy in pregnancy cannot be understood solely as the exercise of individual choice. Drawing on relational autonomy, women's decision-making is shaped by social expectations of motherhood, clinical power dynamics, and familial and cultural pressures that implicitly frame the foetus as a separate moral patient [53, 54]. This relational context may make it difficult for women to assert their preferences, and equally challenging for clinicians to evaluate whose interests are ethically primary in moments of disagreement. Therefore, the findings underscore the need for context-sensitive clinical guidance that supports ethically defensible decision-making and encourages shared deliberation rather than hierarchical judgment. Such guidance is crucial in settings like Ghana, where viability is recognized at 28 weeks, and foetal status is often conceptualized in more personhood-oriented terms [55], further complicating the maternal–foetal moral landscape [55].

Maternal autonomy

According to the principles of beneficence and utilitarianism, clinicians are expected to recommend treatment options where benefits outweigh burdens, prioritizing patient welfare above personal or external interests [35, 56]. In the context of maternal–foetal conflict, gynaecologists and midwives carefully weigh risks and benefits for both mother and foetus. This study showed that beneficence for the pregnant woman generally takes precedence, reflecting both ethical and legal norms in Ghana, where maternal survival is prioritized under the Criminal Offences Act of 1960 [57]. However, midwives also recognized circumstances where foetal interests could constrain maternal autonomy, particularly if the foetus is attributed equal moral status.

The study highlights the ethical challenges clinicians face when balancing maternal autonomy with foetal welfare, especially in cases regarding foetal viability. Participants noted instances where women's preferences for treatment, delivery, or continuation of pregnancy were negotiated, considering what was perceived as best for the foetus. From a principlism perspective, respecting the pregnant woman's autonomy is crucial, as she has the right to make informed decisions about her body and clinical care [51]. However, clinicians often felt compelled to weigh this against beneficence and non-maleficence toward the foetus, especially when continuing or altering care could substantially influence neonatal outcomes. This tension reflects longstanding debates in maternal–foetal ethics, where some clinicians implicitly assign the foetus a patient-like moral status once viability is presumed [52].

However, applying a relational autonomy lens complicates simplistic notions of individual choice. Women's decision-making in pregnancy is shaped by social, familial, cultural, and economic constraints, not merely individual preferences [58]. Clinicians in this study acknowledged that decisions were often made collectively with partners or family members, and in some cases, paternal preferences were prioritized when the woman was perceived as emotionally distressed or lacking decision-making capacity. Such practices demonstrate how autonomy is enacted in contexts of relational interdependence rather than isolation. At the same time, the risk is that relational decision-making may drift into paternalism, where maternal voice becomes subordinated to perceived foetal interests or partner authority. Ethical guidance is therefore essential to help clinicians differentiate supportive relational decision-making from coercive or undermining dynamics, ensuring that protection of foetal welfare does not inadvertently erode women's moral agency.

Foetal status

The moral and legal status of the foetus remains one of the most contested issues in maternal–foetal ethics. Advances in diagnostic imaging and intrauterine care have reinforced perceptions of the foetus as a potential patient, raising questions about whether it should be recognized as a distinct moral or legal person [6, 35].

This study found that midwives generally regarded the foetus as a patient only once it was considered viable, typically around 28 weeks' gestation. This position reflects a clinically grounded understanding of foetal status, shaped by the point at which neonatal survival is considered possible within available health system resources in Ghana [59]. Although many Ghanaian communities ascribe status to the foetus from conception, midwives described viability as the threshold at which the foetus becomes an independent subject of clinical concern. This divergence illustrates the influence of biomedical, legal and practical considerations, rather than purely cultural or religious beliefs, in determining how foetal moral status is interpreted in practice [60].

While Ghanaian law does not define a clear gestational threshold, the Criminal Offences Act of 1960 permits termination only in limited circumstances, such as risk to the woman's life, rape, incest, or severe abnormality [36]. After viability (24–28 weeks), stricter professional scrutiny is applied, suggesting an implicit shift toward considering the foetus as a potential rights-holder [52, 61, 62].

In African bioethics, communitarian perspectives further complicate the debate. As Tangwa and Wiredu note, personhood is socially ascribed rather than automatically conferred at biological thresholds [19, 62]. Thus, foetal status is often framed through relational ties, cultural values, and family decision-making rather than universal rights, underscoring why consensus on foetal personhood remains elusive [19, 62].

Globally, scholars such as Chervenak and McCullough argue that the foetus should be considered a patient only when it can reasonably benefit from medical intervention, either upon reaching viability or when the pregnant woman confers such status through her autonomous choice [52, 61]. This aligns with findings from Ghanaian midwives in this study, who reported that the foetus is regarded as a patient only once it is viable and capable of surviving independently. Before viability, its moral significance is mediated entirely through the woman's decision to accept or refuse treatment [35, 63].

Clinical implications

These findings highlight the need for clinicians to integrate ethical reflection into maternal–foetal decision-making. Such conflicts should be anticipated, and communication with the mother should start as soon as possible. The health system should work on appropriate

guidelines to support health workers in decision-making and patient care. Strengthening communication skills, respecting maternal autonomy, and recognizing the cultural and religious contexts that shape choices are essential for patient-centred care. Structured ethical guidance and training could support healthcare providers in balancing maternal rights with foetal interests while reducing moral distress in practice.

Conclusion

This study underscores the critical need for a structured ethical framework to guide clinical decision-making in maternal–foetal conflicts at the facility and national level. Current reliance on medical/clinical protocols without clear ethical guidance reveals gaps in patient-centered care, particularly in supporting maternal autonomy and informed consent. Ethical deliberation alongside medical assessment is essential to ensure that treatment decisions respect the pregnant woman's rights while considering the interests of the foetus.

The findings highlight that resolving maternal–foetal conflicts requires a shared understanding of when the foetus acquires legal and moral status. Incorporating case-specific consent processes and integrating sociocultural and religious perspectives into clinical practice can foster a more ethically sound approach. Ultimately, developing context-sensitive ethical guidelines will support healthcare providers in navigating complex maternal–foetal dilemmas, balancing beneficence, autonomy, and justice in ways that are legally, culturally, and clinically appropriate.

Limitations of the study

This research contributes to our knowledge of maternal-foetal conflict, particularly within the context of Ghana, a country that highly values cultural and religious beliefs. However, this study has some limitations. It was conducted in a peri-urban community in Ghana and may not be fully representative of other districts, regions, or populations. The geographical constraints could impact the applicability of the findings to different settings or ethnic groups, as the sample is specific to a particular location and demographic.

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12910-025-01376-1.

Supplementary Material 1.

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Authors' contributions
ZH: conceptualization, proposal write-up, funding, data collection, analysis, report write-upMAC: proposal write-up, analysis, report write-up. Both authors approved the final version of the manuscript.

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Data availability
The data for this study are not publicly available due to the sensitive and confidential nature of the in-depth interviews conducted with healthcare professionals. However, de-identified excerpts of the data may be made available from the corresponding author upon reasonable request and with appropriate ethical clearance.

Declarations

Ethics approval and consent to participate
Approval was sought from the Institutional Review Board of Dodowa Health Centre, with ethics approval number DHRCIRB/209/10/22. The study was carried out in conformity with the Helsinki Declaration, and each participant provided written informed consent.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

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