Who is Captain of the Ship? Informed Consent & Refusal in Obstetrics

Stockholm Regional Guideline Meeting
Karolinska University, Sweden
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No conflicts of Interest

Objectives

My VBAC with a BMI of 40 refuses to leave my level 1 center. My nurses and GPA are freaking out.

What now?

Objectives

- Ethics of autonomy & beneficence
- Culture of risk avoidance
- The therapeutic alliance
- Modern “Informed Consent”
- Geographical implications
- Legal implications

Autonomy & Beneficence

- Autonomy:

- Beneficence:

Autonomy & Beneficence

- Autonomy: an individual's right to make their own health care decisions

- Beneficence: clinicians' imperative to do what is best for a patient

Autonomy = Beneficence

Autonomy ⟷ Patient

Beneficence ⟷ Caregiver

Autonomy ≠ Beneficence

Exploring Values

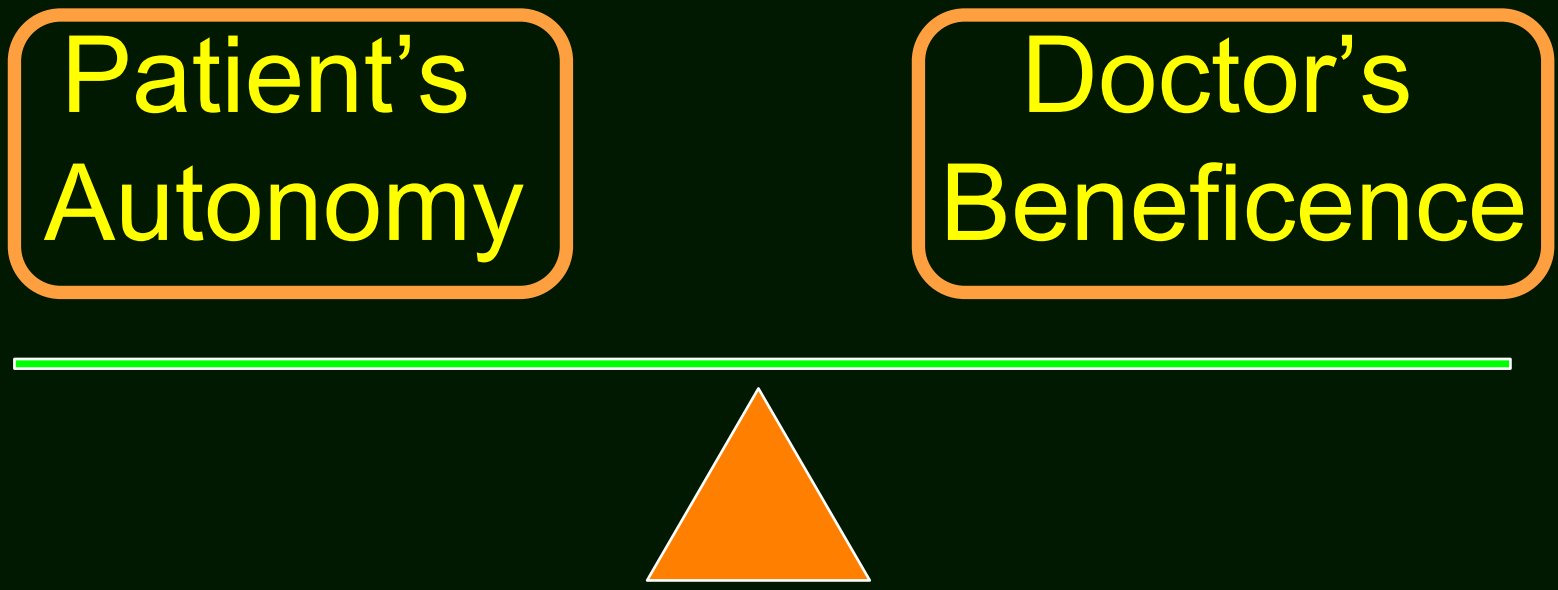
- Patient values:
  - Anecdotal experiences
  - Individual circumstances
  - Misconceptions
  - Emotional fears
  - Religious beliefs
  - Patient preference
- Clinician values:
  - Anecdotal experiences
  - Individual clinician skills
  - Misconceptions
  - Emotional fears
  - Religious beliefs
  - Clinician preference

Objective, evidence-based, clinical judgment

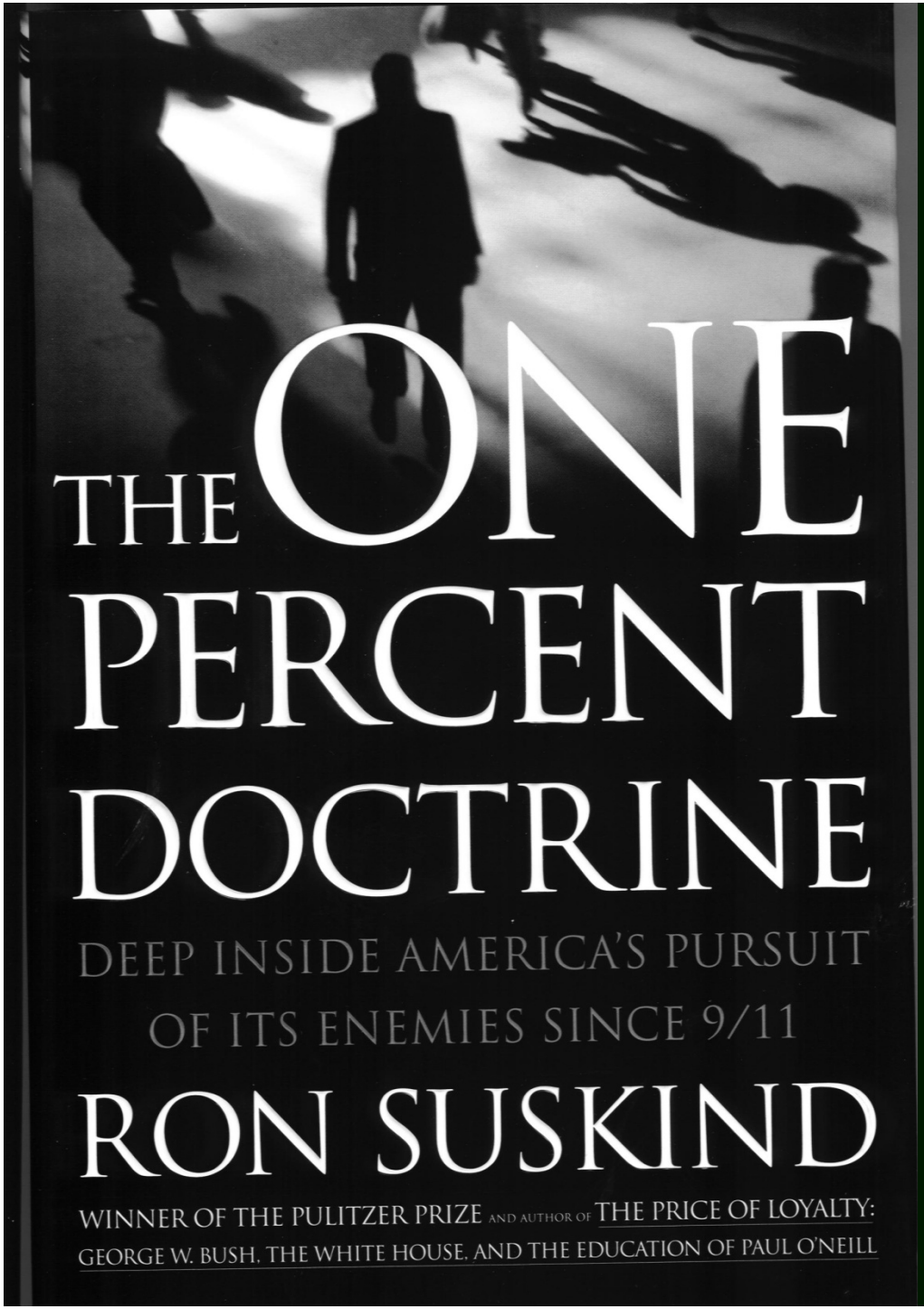
Autonomy ≈ Beneficence?

Autonomy vs. Beneficence

Autonomy vs. Beneficence

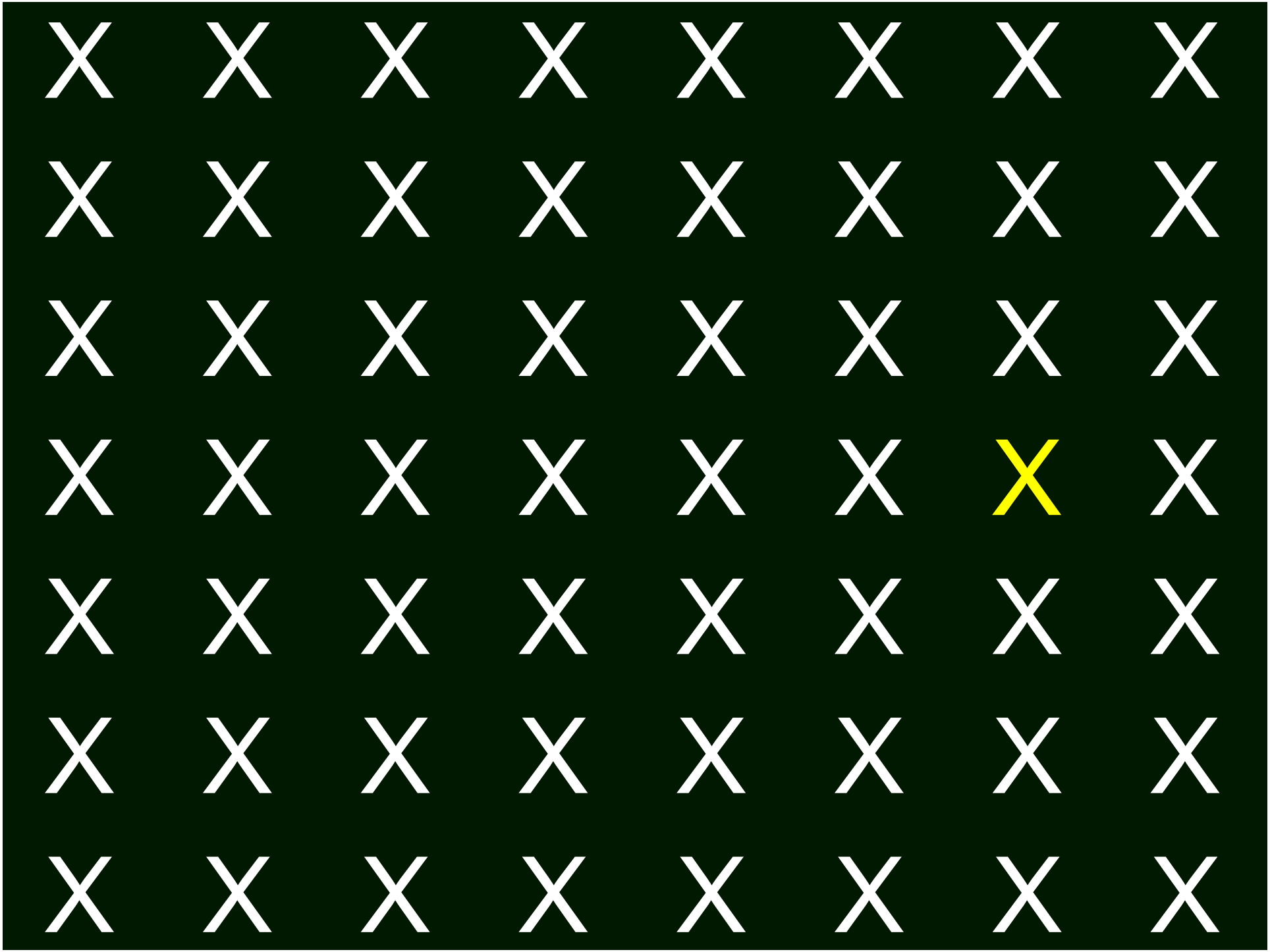


Whose values decide?



"If there's even a 1% chance of an … act occurring, we must treat that as if it were a certainty."

(Dick Cheney, 2001)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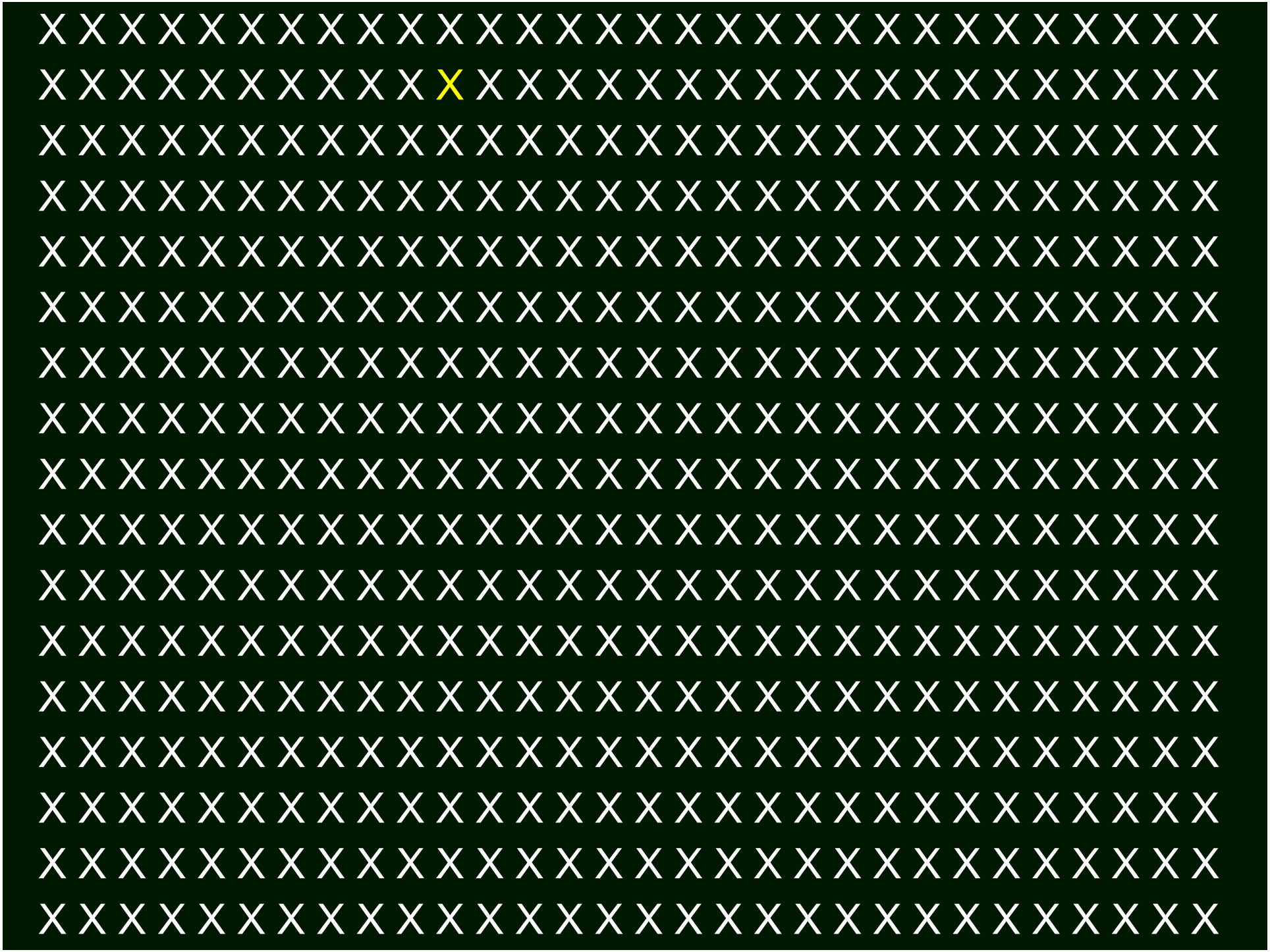
BASE Jumping 1/500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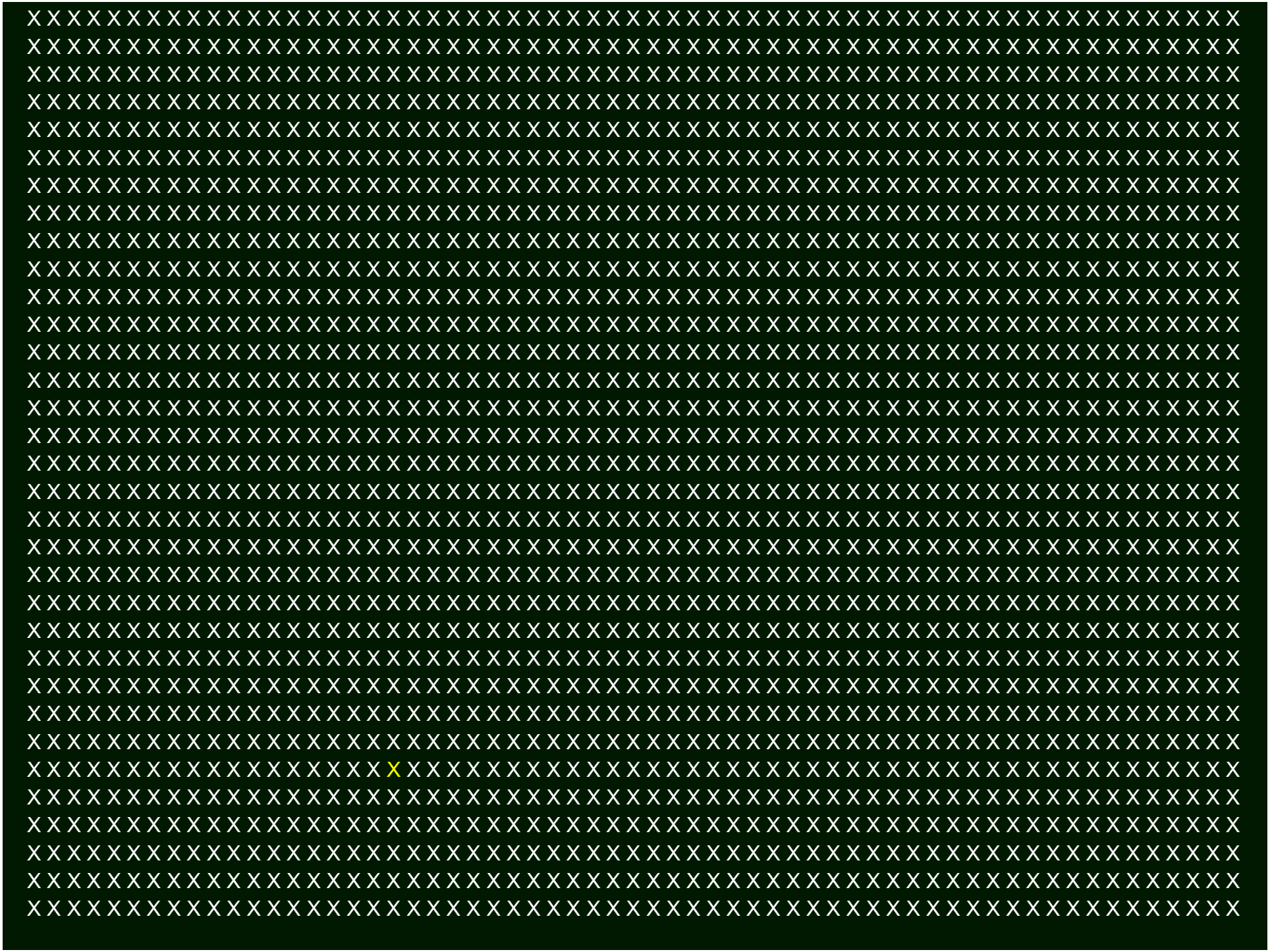
Vaginal Birth after Cesarean (VBAC)



Clinical Decision Making

Offer, Recommend, or Coerce?

- Offer: equipoise (risk = benefit)
- Recommend: endorse a preferred (or safer) clinical course of action

- Coerce: compel by force of authority

Obstetrical Risks

- VBAC rupture causing PN death or HIE:
  - Spontaneous labour 1/2000
  - Induction of labour (PG or oxy) 1/1000
  - 2 prior C/S 1/1400
- Background stillbirth risk:
  - 40 – 41 weeks 1/1200
  - 41 – 42 weeks 1/900
- Breech birth risk of PN death:
  - Careful trial of labour: 1/700
  - Planned C/S 1/2000

Recommend or Coerce?

- Recommend: endorse a preferred clinical course of action

- Coerce: compel by force of authority

Coercion ≠ Consent

Obstetrical Risks

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  - Planned homebirth with midwife (USA)

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Maternal death prior C/S

What is the risk of maternal death with a prior C/S?

Trial of labour (all): 1:
Successful VBAC: 1:
Emergency C/S: 1:

Elective repeat C/S: 1:

Landon NEJM 2004;351(25):2581-9

Maternal death prior C/S

What is the risk of maternal death with a prior C/S?

Trial of labour (all):	1:	6,000
Successful VBAC:	1:	13,000
Emergency C/S:	1:	
Elective repeat C/S:	1:	

Landon NEJM 2004;351(25):2581-9

Maternal death prior C/S

What is the risk of maternal death with a prior C/S?

Trial of labour (all):	1: 6,000*
Successful VBAC:	1: 13,000
Emergency C/S:	1: 2,400
Elective repeat C/S:	1: 2,300*

* Difference not statistically significant +
* Future placenta accreta; previa; etc. not measured

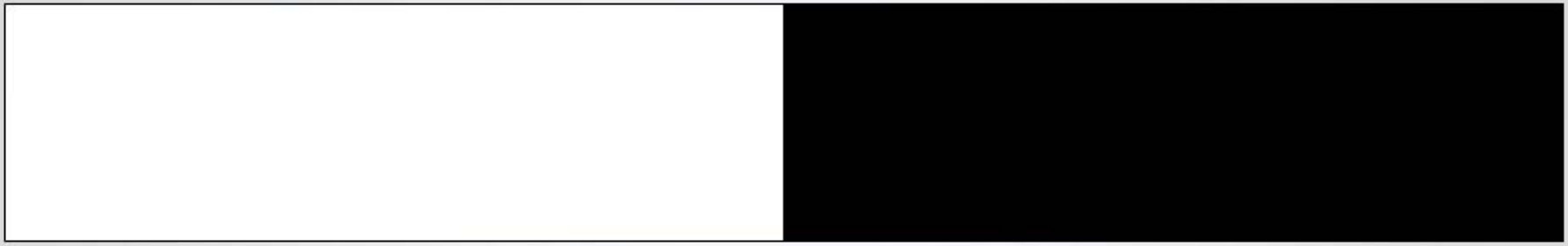
Landon. NEJM 2004;351(25):2581-9

A Clinician's 5 Choices

A. Force treatment = deny natural Hx
B. Recommend treatment
C. Offer treatment
D. Recommend against treatment but provide it if requested
E. Refuse to treat = force natural Hx

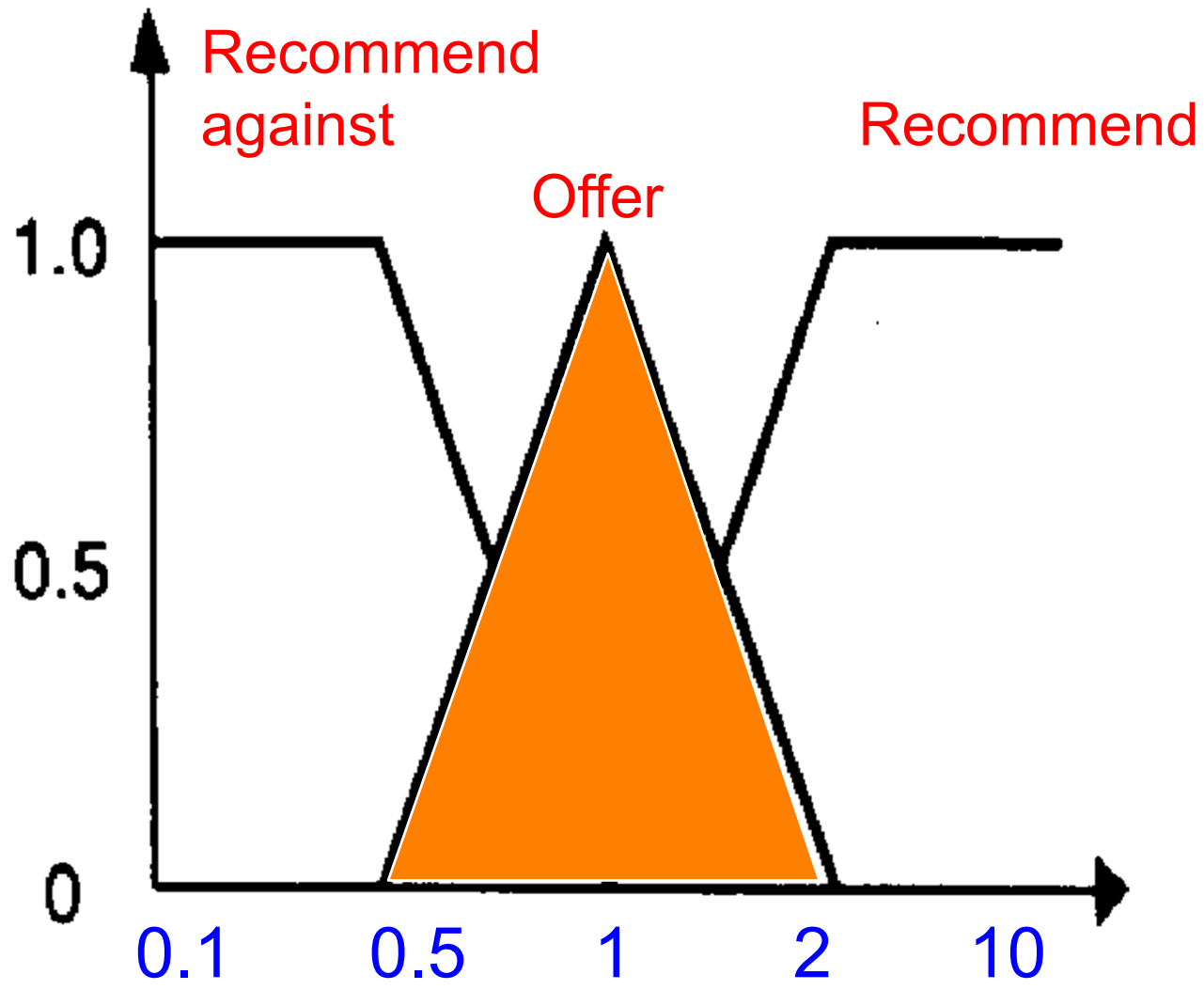
Black and White Thinking

BLACK & WHITE THINKING



GiovanniBaldi.com

CRITICAL THINKING



Likelihood ratio: Benefit vs. Harm

Lotfi A. Zadeh

VBAC Examples

1. Prior classical cesarean section
2. 2 prior C/S for recurring indication; 41+ weeks; unripe cervix
3. Prior breech C/S; oligo @ 40 weeks; favorable cervix
4. Prior breech C/S; spontaneous labour
5. Prior breech C/S; prior successful VBAC; spontaneous labour, 6cm

Autonomy vs. Beneficence

Autonomy > Beneficence

Autonomy < Non-Maleficence

Every patient has a right to experience the natural course of their condition.

Every patient has a right to be cared for as this natural course unfolds.

Therapeutic Alliance

- Balance of:
  - Best research
  - Clinical expertise
  - Patient values

To form an alliance which optimizes clinical outcomes and quality of life

(David Sackett)

Therapeutic Alliance

- How do you stay “with” a patient when she declines your recommendation?
  - Careful communication & documentation
  - Ego in your pocket
  - Relinquish locus of control
  - ‘Detached caring’ (not an oxymoron)

Therapeutic Alliance

- Give your clinical opinion:
  - “Recommend” vs. “offer”
  - Qualify your recommendation: strong? mild?
- Explicitly state your commitment to her autonomy over your idea of beneficence:
  - Your job is to inform and care for her
  - She is free to decline your recommendation
  - She will not lose your care if she declines your recommendation

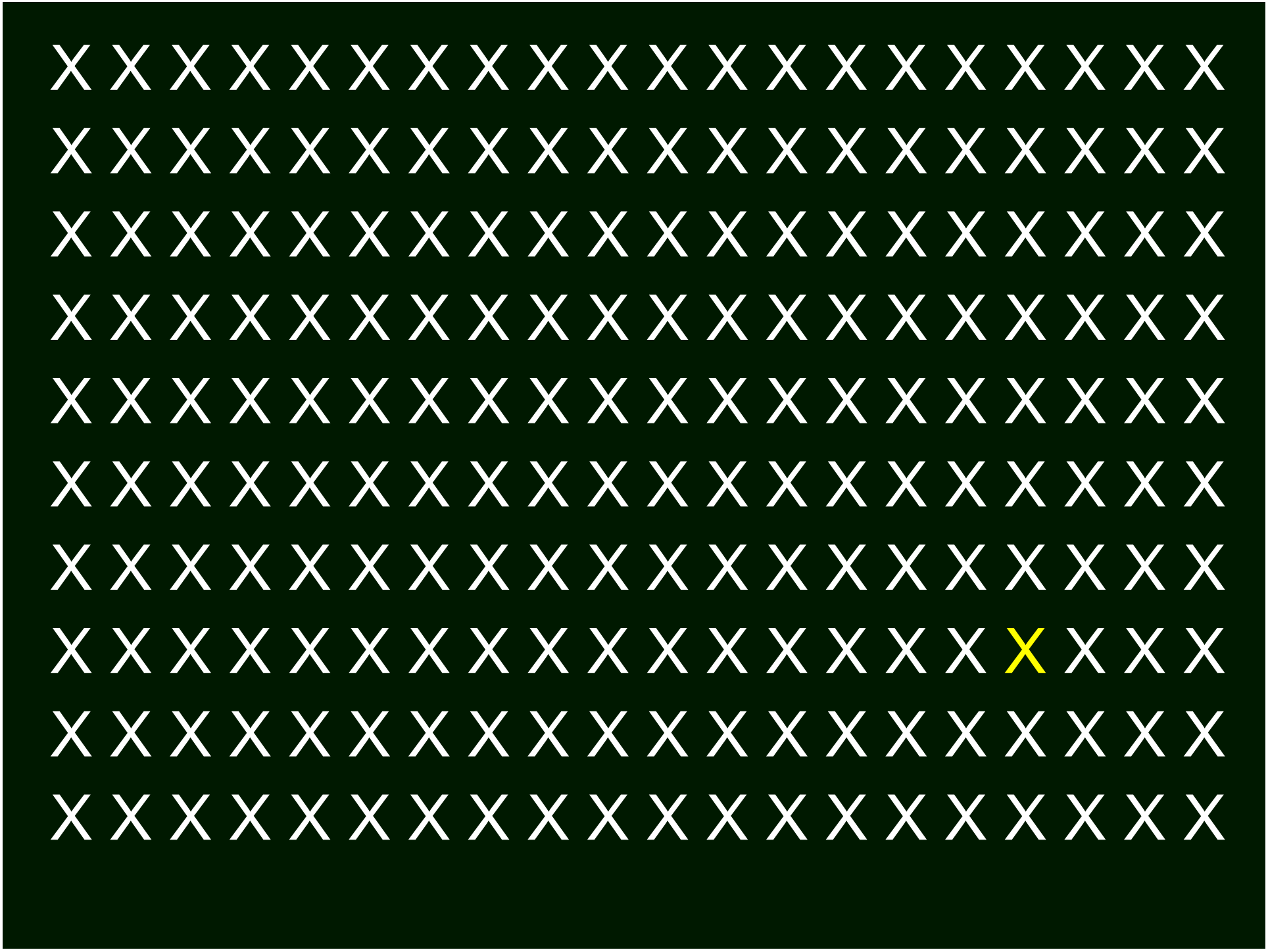

RØDE SEL
ROOTS

Supporting a woman's right to choose does not mean you are supporting her choice.

Therapeutic Alliance

“ I felt in control and taken care of.”

(Listening to mothers 2006)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Clear clinical direction:
"Recommend" vs. "Offer"

Commitment to Patient Autonomy

Emotional detachment

Informed Consent

1. Pt understands the diagnosis
2. Pt knows the natural course without Tx
3. Pt is aware of the treatment options
4. Pt understands the risks & benefits of the options, including doing nothing
5. Pt can decline recommendations or choose alternatives without prejudice

Key Points

- Autonomy trumps beneficence,
- The therapeutic alliance is sacred,
- Keep your values in perspective,
- Keep your ego in your pocket,
- Don’t be afraid to recommend,
- Don’t take it personally if a woman, declines your recommendation, and
- Keep caring for your patient.

COMMENTARY

WILEY BIRTH

Informed consent and refusal in obstetrics: A practical ethical guide

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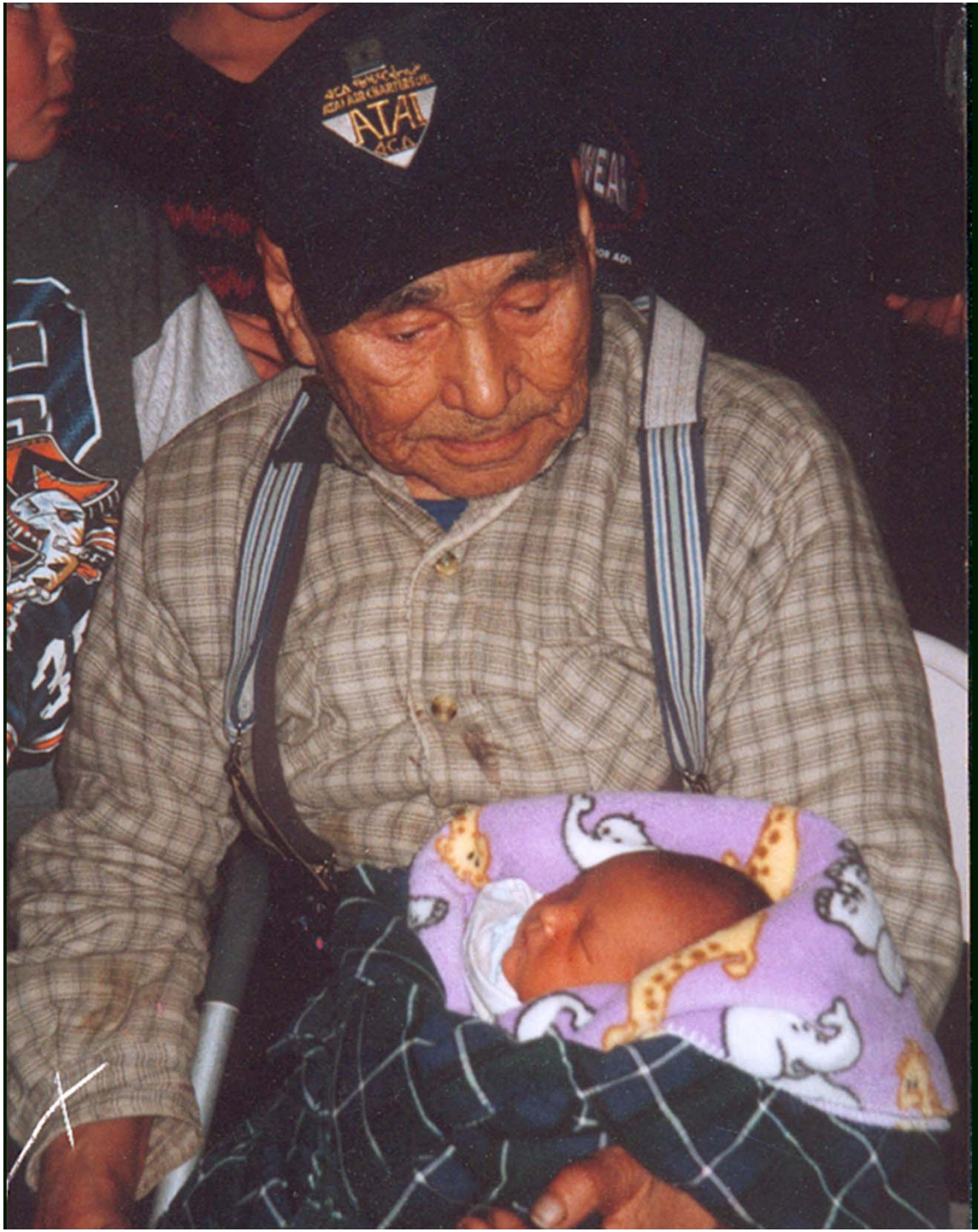

“ I can understand that some of you may think that birth in remote areas is dangerous. And we have made it clear what it means for our women to birth in our communities. And you must know that a life without meaning is much more dangerous.”

Jusapie Padlayat
Elder, Salluit Health Board

Homebirth Case: B.C.

- 30 Y/O G3T2 at term
- 1 prior C/S for breech
- 1 prior successful VBAC
- Normal antenatal course
- Complete breech presentation
- Normally grown fetus
- Midwifery care

Homebirth Case: B.C.

- Referred to OB #1
- Attempted ECV unsuccessful
- “Offered” C/S - Client declines
- Midwife arranges consult with OB #2
- Again “offered” C/S - Client declines
- Midwife offers to arrange care at distant center where TOL more available. Client declines

Homebirth Case: B.C.

- MW explains breech outside of scope and advises cannot attend homebirth, in accordance with CMBC policy
- Patient labours at home unattended – spontaneously delivers breech baby boy
- Ambulance called when infant fails to breathe spontaneously

Homebirth Case: B.C.

- Ambulance crew resuscitates baby and transfers it to hospital.
- Baby weighs 3.5 kg; ventilated and transferred to SCN; dies 12 hours after birth from hypoxic multisystem organ failure and ischemic encephalopathy

Questions:

- Did the obstetricians make a reasonable effort to obtain informed consent?
- Is it ethical to threaten to abandon a patient in order to coerce them to do what we think is best?
- Could the midwife have done anything different?
- Can “attending out of scope” cause harm?

CMBC Policy 2008

"If … the client refuses to follow the recommendations arising from the consultation … the midwife shall:

… inform the client that she will be unable to continue to provide midwifery care (and) make a reasonable attempt to assist the client to find another caregiver.

… follow-up immediately with a … registered letter … confirming termination of care by a date which provides the client with a specific amount of time to find another caregiver."

Royal College of Midwives

“If a woman rejects your advice … you must continue to give the best care you possibly can, seeking support from other members of the health care team as necessary”

A Maternity Care Provider's Pledge:

To my pregnant patient:

1. My colleagues and I have a duty to provide you with competent clinical care. We will not abandon this duty.

2. I will offer or recommend treatment that I believe to be in the best interest of you and your fetus.

3. I will provide you with information as objective and unbiased as possible about the natural course of your clinical diagnosis or situation and the risks and benefits of treatment options.

4. I will respect your right to accept or decline any recommended intervention.

A Maternity Care Provider's Pledge:

5. If you decline a recommended intervention, I will continue to care for you; however, this does not mean that I support your decision. You bear the ethical and legal responsibility for any harm to you or your baby that might arise from your informed refusal.

6. You may change your mind. If clinical circumstances change your level of risk significantly, I will inform you of this and give you an opportunity to change your decision.

7. I will not perform an intervention you request if I believe it will do more harm than good; however, I will refer you to a colleague who would reasonably honor such a request.

Informed Refusal Documentation

My caregiver has informed me of the risks of refusing this advice, including possible death to me and/or my fetus.

I expect to still receive courteous, professional care.

I have the right to later accept my caregiver's recommendation.

I accept that my caregiver will refuse to perform an intervention that he or she believes is unsafe; however, intra-partum care and attendance in labor are not interventions. My caregivers have a duty to continue to provide me with care.

I understand that a health care practitioner providing care after I have declined his/her recommendation is not endorsing my choice; rather he/she is respecting my right to choose.

I accept that I am legally and ethically responsible for harm to me and/or my unborn child that arises from my rejection of a health care provider's recommendation.

A Birthing Woman's Rights & Responsibilities

1. According to my beliefs & values, I have the right to make health care decisions for me and my fetus. No other's concern for me or my fetus shall supersede this right.

2. I have a right to receive objective, unbiased health care information including:

- the natural course of my condition without treatment;
- treatment options available locally and elsewhere;
- the risks and benefits of different options, including doing nothing.

3. I understand that health care providers have a duty to recommend care that they judge to be in my best interest.

4. I have a responsibility to engage in discussions regarding care options, risks, and benefits in order to reach informed choices based on my values.

5. I have the right to decline without prejudice any intervention recommended by a health care professional, even if my decision increases my and my fetus' risk of harm or death.

A Birthing Woman's Rights & Responsibilities

6. If I decline a recommendation, I have the right to receive courteous, professional care.

7. I have the right to change my mind: to accept a recommendation that I have previously declined; or to decline a recommendation I have previously accepted.

8. I accept that a health care practitioner has a duty not to perform an intervention that he or she believes is unsafe; however, intra-partum care and attendance in labor are not interventions and a health care practitioner has a professional duty to continue to provide care.

9. I do not have the right to demand an intervention that a health care provider believes is unsafe; however, if another licensed practitioner would reasonably honor my request, I have the right to be referred to them.

10. I understand that a health care practitioner providing care after I have declined his or her recommendation is not endorsing my choice; rather he/she is respecting my right to choose.

11. I accept that I am legally and ethically responsible for harm to me and/or my fetus that arises from my rejection of a health care provider's recommendation.