Bioethical Decisions: Vulnerable Patients in Maternal-Child Healthcare

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BIOETHICS

Ethics is knowing the difference between what you have a right to do and what is right to do.

Potter Stewart

Physician-assisted suicide
Abortion
Genetic testing
Informed consent
Doctor-patient confidentiality
Bioethics is a shared, reflective examination of ethical issues in health care, health science, and health policy.

“To establish what ought to be the guiding principles of healthcare is not an easy task. There are many varying perspectives.”
--- Adelaide Centre for Bioethics and Culture

Key: These ethical questions are different for each country and each state within countries, and involve a myriad of complexities.
Definitions and Terms

• Objectives:
  • Identify common ethical challenges occurring in the maternal-child specialties.
  • Understand the difference between maternal autonomy and fetal autonomy.
  • Review and understand the parental authority does not equal parental autonomy.
Case Scenarios

Scenario #1
Maternal decision-making rights vs. fetal rights

**Vulnerable patient:** Fetus

**Ethical dilemma:** rights of the women compared to the rights of the viable fetus.

**Impact consideration:** With improved care technology at what point in the gestation of pregnancy does the fetus, who can successfully live outside the womb, take precedence over the mother’s autonomy over her own body regarding medical interventions.

Scenario #2 Care decision-making roles and responsibilities between physicians and families

**Vulnerable patient:** Newborn

**Ethical dilemma:** At what point are medical interventions being provided to ease the suffering and provide hope for parents.

**Impact consideration:** Are the neonatologists required to proceed with potentially painful procedures and interventions when they have deemed further medical care as futile. At what point does their professional medical opinion and plan of care outweigh the wishes of the parents to pursue further intervention.

Scenario #3 When does the needs of the family outweigh the medically acceptable management approaches?

**Vulnerable patient:** The Mom and the Fetus.

**Ethical dilemma:** Do we allow premature non-medical inductions to occur to support the emotional and psychological well being of the mother when there is no medical necessity to cause labor?

**Impact consideration:** Is it appropriate to allow non-medically indicated procedures to occur knowing the death of the infant will be hastened in doing so?
Scenario 1: Maternal decision-making rights vs. fetal rights

Vulnerable patient: Fetus
Ethical dilemma: Maternal Autonomy vs. Fetal Autonomy
The rights of the women compared to the rights of the viable fetus.

- With improved care technology at what point in the gestation of pregnancy does the fetus, who can successfully live outside the womb, take precedence over the mother’s autonomy to make medical decisions about her own body.

- **Situation:** A pregnant woman was admitted 4x into the hospital to detox from alcohol. All four admissions were unsuccessful. At 35 weeks gestation the infant is considered to have a high likelihood of survivability outside the womb. 35 weeks gestation is categorized as a “late preterm infant”.

- **Questions to Consider:**
  - When is personhood established? When does the fetus have rights? Who is the physician’s patient?
  - What medical responsibility does the provider have to the fetus to ensure appropriate prenatal care?
  - Can/Should the physician admit the patient for detox against their will?
  - What responsibility does the mother have to not participate in known activities that are harmful to the fetus?
Fetal vs. Maternal Moral Autonomy

Three major ways of viewing the moral status of the fetus

1) That the fetus has the same rights as a live child.

2) That the fetus has no rights.

3) That a fetus has increasing moral status with advancing gestation.

**Full Fetal Rights**

- Person’s autonomy is one of choice. A person’s right to how to live their own life.
- No Society forbids a woman from smoking during pregnancy.
- If a fetus has full rights, this could encourage legislation against maternal activities that might damage a fetus.
- Assigning full rights to the fetus might infringe upon a mother’s autonomy.

**No Fetal Rights**

- Perspective that the fetus has no moral status independent of the mother.
- The fetus acquires moral status upon birth.
- Upon birth the fetus transitions to be a member of the social world.
- One implication might be that a woman has the moral rights to abort a viable fetus, but not to kill her newborn infant.

**Moral Status of a Fetus Increases With Gestation**

- There is a moral difference perceived by many between an early pregnancy and a late pregnancy, such as in abortion, implies a full-term fetus acquires moral status with increasing gestation.

(Isaacs, 2003)
Maternal Accountability for Fetal Exposure vs. Forced Interventions During Pregnancy.

• As of 2011, no statutory criminal law that specifically permits the arrest or detention of women with regard to their pregnancies.
  • Examples: Detention of women involving a hospital or other institutional confinement for substance abuse treatment. In 1992, a Florida judge “committed pregnant addicts to drug treatment in jail under the same mental health law used to commit the insane.” (Patlow & FLavin, 2013)

• Case examples:
  • 1999, Laura Pemberton, chose to have a VBAC (vaginal birth after c-section) and her doctor sought a court order to force her to have a c-section. The judge presiding over the case compelled her to undergo the operation. She later sued for violation of her civil rights, the district court ruled that it’s in the state’s interest in preserving the life of the fetus outweighed Pemberton’s rights under the 4th, 5th, and 14th Amendment. She subsequently gave birth to 3 more children vaginally. (Patlow & FLavin, 2013)
Perceptions of Healthcare Providers

- Caregiver’s attitudes and beliefs towards women in regards to “autonomy”, “decision-making”, and birth....

- What is the legal responsibility of the healthcare professional for maternal and fetal outcomes?
  - Doctors believe themselves ultimately accountable for the birth experience. *Legally they are only responsible for the adverse outcomes caused by negligent actions.*
  - ‘For the safety of the baby, the maternity care team sometimes need to override the needs of the woman.’ --- Common Western Philosophy
Scenario 2: Care decision-making roles & responsibilities between physicians and families

• Vulnerable patient: Newborn

• Ethical dilemma: Parental autonomy and medical beneficence may be in direct conflict with one another.
  - Are the neonatologists required to proceed with potentially painful procedures and interventions when they have deemed further medical care as futile? At what point does their decision outweigh the wishes of the parents?

• Situation: A 26 week gestation infant is on a ventilator, IV therapy for hypotension, and the child has 2 chest tubes for pneumothoraxes. The chest x-ray reveals the infant could restore some lung function. However, the overall status of the infant is declining and death is likely to occur within a few hours despite additional chest tube placements.

• Parental authority outweighs physician recommendations ---- continued care is being requested, including potentially painful procedures, when a provider’s perspective is the death of the infant is inevitable. The parents are mandating the chest tube be placed.

Options Considered:

1) the physician decides to put the chest tube in (is this an ethical decision all by itself because the provider doesn’t feel this is a necessary procedure and that it’s not in the best interest of the child?)

2) The parent decides to follow the providers recommendations.

3) The parent and the physician are at an impasse. (is the hospital/provider required to bring in another physician, if available, to assume care?)
If I Would Have Known…

Parental Autonomy to make the decision... in the moment.

Alexia Pearce looks at her three-year-old son Nathan every day and feels the same rush of guilt. Guilt that she chose to let him live when he was born too early, just 23 weeks into her pregnancy.

"If I'd known then what I know now about what extremely premature babies have to go through, I would not have chosen that for my little boy."

"He can't walk or talk. He's oxygen dependent, although hopefully that might change. He has chronic lung disease, cerebral palsy and global developmental delay. He has diabetes insipidus and his thermostat is a bit wonky so he gets hot and cold."
Scenario 3: When do the needs of the family outweigh the medically acceptable management approaches.

- **Vulnerable patient:** The mom and the fetus.

- **Ethical dilemma:** Do we allow premature non-medical inductions to occur to support the emotional and psychological well-being of the mother when there is no medical necessity to cause labor.

- **Situation:** 28 year old women who was 34 weeks along asked to be induced to allow her infant, who had a known lethal anomaly, to be born when her husband could be at her side. Elective induction of labor is not medically supported until a pregnancy reaches 39 weeks. The nursing staff expressed their lack of comfort with the medical plan for an early induction because the premature birth would hasten the death of the infant.

**Questions to consider:**
1) If the mother had requested an induction of labor because her friend was in town would we have allowed it?
2) When does the emotional, not physical, well-being of the mother take precedence over the rights of the fetus to develop to term?
3) Is this an abortion? 4 Nursing staff chose to recused themselves from participating in the delivery of this infant due to personal beliefs.
4) Does the need for c-section change the decision-making pathway? Performing a c-section, a major abdominal surgery, electively has negative consequences on the mother’s long reproductive health.
Parental Authority vs. Parental Autonomy

- A child has the right to mercy. Defined as the right not to be made to experience unnecessary suffering.
  - This would include pain that results from treatment that offers no significant benefit to the child. (Cummings & Mercurio, 2011)

- **Parental Authority**- parents are generally accorded the right to make medical decisions on the child’s behalf.
  - Parental authority is not absolute.
  - US Supreme Court expressed, “Parents are free to become martyrs themselves. But it does not follow that they are free, in identical circumstances, to make martyrs of their children...” (Cummings & Mercurio, 2011)

- **Parental Autonomy**- An autonomous decision is one made with adequate information and understanding (competence) of the implications of various possible outcomes. (Cummings & Mercurio, 2011)
  - Most fundamental component of competency is the right to refuse unwanted treatment. This does not necessarily include the right to demand any therapy.
Other considerations...

Maternal minor decision-making.

- Currently, in the state of Idaho “Maternity” is the definition of autonomy for underage women. In the hospital setting a woman who is under the age of 18, gives birth to a newborn, she can sign for all medical consents for treatment for the infant but, she can’t sign for medical consent for her own medical care. Her parent(s) must sign medical consent.

Women’s rights to have the option to select a vaginal delivery or cesarean birth.

- Risk to newborn to developing HIV from exposure during birth is 25%. Therefore, anti-retroviral medications and c-section birth is the preferred treatment in the last weeks of pregnancy. Does a woman have the right to refuse retroviral medication or a c-section? To deny these rights for her to chose goes against her right to autonomy.
Any Questions?

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