

## The ethical decision making model in obstetrics and gynaecology practice

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**Abstract:** This paper attempts to utilise clinical scenarios where ethical issues are embedded and requires appropriate application of the steps of the framework mentioned. A step by step sequential approach is adopted to illustrate how the 'ethical decision model' can be used to resolve ethical problems to arrive at a reasonable conclusion. The UNESCO ethical method of reasoning is used as the framework for decision making. Physician-educators should be competent to use ethical decision models as well as best available scientific evidence to be able to arrive at the best decision for patient care as well as teach health professional trainees how reasonable treatment decisions can be made within the perimeter of medical law and social justice.

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### Introduction

Work-based learning facilitates contextual learning using real clinical cases. In certain situations in the clinical setting health care providers would be required to apply the code of ethics for decision making. Clearly organisations that draw codes on regulations only provide broad guidelines and would not address specific issues arising from individual cases. This leaves the clinician or carer to apply basic ethical principles based on the five common moral principles often quoted i.e. autonomy, beneficence, non-maleficence, justice and fidelity.

Ethics is based on philosophical derivatives that is theoretical but can be meaningfully applied to the practical issue at hand. The language of ethics refers to duties and values often governed by local culture and personal approaches to the profession. A framework for decision making is often used to assist clinicians to achieve fair determinants of care. One such example is the 'American Counselling Association: A Practitioner's Guide to

Ethical Decision Making'.<sup>1</sup> This model has been used by most organizations and an adaptation of the original by the United Nations Educational, Scientific and Cultural Organisation (UNESCO) is shown in Box 1.<sup>2</sup>

### The Professional Framework on Ethical Decision Making

This paper attempts to utilise clinical scenarios in the clinical setting where ethical issues are embedded and requires appropriate application of the steps of the framework mentioned. A step by step sequential approach is adopted to illustrate how the 'ethical decision model' can be used to resolve ethical problems to arrive at a reasonable conclusion.

The fundamental sequence of events is to recognise the problem at hand and seek clarification as to the complexity of the problem. Is it a single issue or are there a multitude of issues that may be compounded by ethical, professional, clinical and legal problems? It is at this stage that one determines further the dimensions of the problem and if an ethical dilemma is obviously apparent. One needs to decide which of the five or so ethical principles apply either independently or in combination when prioritisation and further deliberation is required.

Brainstorming within a group helps in both learning and resolution and provides a stage for younger members of the team to learn the ropes of ethical decision making. By considering all options available, a course of action would be generated. The aim is to derive a decision that would best fit the situation.

Having considered the best course of action, review the decision to ensure it presents a harmonious resolution for the situation. Stadler (1986) suggests applying three simple tests to the selected course of action to ensure that it is appropriate. In applying the test of justice, assess your own sense of fairness by determining whether you would treat others the same in this situation. For the test of publicity, ask yourself whether you would want your behaviour reported in the press. The test of universality asks you to assess whether you could recommend the

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same course of action to another counsellor in the same situation.<sup>3</sup>

The final phase of the decision making model is eventually to implement the course of action decided. It is always recommended that a decent time of follow up is required so that one learns from the whole exercise as to the applicability of ethical principles, if best judgement prevails and all actions were done with no malice and personal gain.

In obstetric and gynaecologic practice, physicians encounter numerous situations which are ethically challenging which require ethical decisions to be made. Three common such situations are described to illustrate how ethical and professional issues are identified and how reasonable resolutions are derived. The UNESCO ethical method of reasoning is used as a model for decision making.

### Case illustrations:

#### Case 1

A 39 year-old Gravida 6 Para 5 at 18 weeks gestation is diagnosed to have a Down's syndrome fetus and requests termination of pregnancy. The fetus is also diagnosed to have a Ventricular Septal Defect following a detailed ultrasound and fetal echocardiogram performed by a maternal-fetal medicine specialist. She claims she will not be able to cope (mentally and socially) with having a child with Down's syndrome. The doctor she consulted is not happy to perform the termination of pregnancy as it is against his religious belief to do so.

Reasoning and ethical decision-making:

*Fact deliberation:* Down's syndrome is a non-lethal genetic disorder that causes lifelong mental disability, developmental delays and other problems such as cardiac abnormalities. The pregnancy is currently at 18 weeks gestation, which is before the age of viability, usually taken at 22 weeks, or 24 weeks in some countries. Termination of pregnancy commonly refers to the

medical procedure where medication is used to induce uterine contractions and cervical dilatation leading to the expulsion of the fetus. The process of pregnancy termination is not without complications, and may pose significant health risks to the patient. The medical practitioner attending to her is exercising his conscientious refusal in refusing to perform the pregnancy termination.

*Value deliberation:* The patient is exercising her autonomy in deciding to discontinue her 'abnormal' pregnancy. As an adult with capacity to decide she has a full and perfect right to determine what may be done to her body. The physician has the professional duty to provide medical care in the best interest of the patient with no or minimum harm. In this situation, the physician has to consider the benefits of pregnancy termination to this patient's health and wellbeing against the potential harm from the procedure as well as the harmful effect if the pregnancy is allowed to continue. Here is also the issue of conscientious refusal of the medical practitioner as the abortion seems to be in conflict with the practitioner's moral/religious value. As the decision affects another being i.e. the fetus, the issue of the rights of the fetus warrants some consideration.

*Duty deliberation:* The extent of patient's knowledge and understanding of the medical facts about Down's syndrome and the process of pregnancy termination should be established before she exercises her autonomy in the decision-making process. The legal implication should also be discussed. This is to ensure that patient is making an informed decision and the physician is working within the legal limits.

*Testing consistency:* From the legal point of view, termination of pregnancy carries medico-legal implications and the law of the country takes precedence over any ethical implications.<sup>4</sup> In Malaysia, section 312 of the Penal Code of Malaysia, which was in effect until 1989, stated that the only legal basis for the performance of an abortion was to save the life of

the pregnant woman, otherwise it becomes a criminal offence. In 1989, the penal code was amended substantially by stating an 'Exception—This section does not extend to a medical practitioner registered under the Medical Act 1971 [Act 50] who terminates the pregnancy of a woman if such medical practitioner is of the opinion, formed in good faith, that the continuance of the pregnancy would involve risk to the life of the pregnant woman, or injury to the mental or physical health of the pregnant woman, greater than if the pregnancy were terminated'.

For this patient, the ground for pregnancy termination is that it will involve mental health risks to her should the pregnancy is allowed to continue. The pregnancy termination could not be carried out solely based on the fact that the fetus is abnormal, unless it can be shown that the abnormality had an effect on the health or life of the mother, which in this case involves the maternal mental health. Equally, pregnancy termination cannot be performed on economic or social grounds. In Malaysia, fetal rights are not factored in in the decision-making process.<sup>5</sup>

In regards to the physician's conscientious refusal, while the physician has the right to refuse to perform certain medical procedures based on his conscience, generally it should be limited if they constitute an imposition of religious or moral beliefs on patients, negatively affect a patient's health, is based on scientific misinformation, or create or reinforce racial or socioeconomic inequalities. In this case, the attending physician has the duty to refer patients in a timely manner to other providers to ensure continuation of care as needed by the patient.<sup>6</sup>

*Conclusion:* it is within the rights of the patient to exercise her autonomy in deciding to discontinue her pregnancy on the grounds of mental distress due to the abnormalities of the fetus and the physician performing the pregnancy termination will still be operating within the limits of law in Malaysia. The physician should refer the pregnant woman to another healthcare provider to provide the abortion services if he conscientiously refused to perform the procedure himself.

## Case 2

A 30 year-old Gravida 3 Para 2 requests to be delivered by caesarean section because she wants to have tubal sterilisation done at the same sitting as she has achieved her desired family size. She is obese, weighing 100kg but has been healthy otherwise. This pregnancy is uncomplicated. She delivered all the other babies normally and without complications.

Reasoning and ethical decision-making:

*Fact deliberation:* The term caesarean delivery on maternal request (CDMR) refers to elective delivery by Caesarean section (CS) at the request of a woman with no identifiable medical or obstetric contraindications to an attempt at vaginal delivery. Caesarean section is a surgical intervention with potential hazards for both mother and child. Major and minor morbidity associated with elective CS has been reviewed systematically in the recent National Institute of Health and Clinical Excellence (NICE) document on Caesarean section, which concluded that there is very little good quality evidence to suggest that risks from elective CS are lower or higher than that of a planned vaginal delivery. It also uses more health care resources than normal vaginal delivery although recent analysis has made the conclusion regarding cost-effectiveness less certain.<sup>7</sup>

*Value deliberation:* The patient is exercising her autonomy in deciding how she wishes to deliver her child. Maternal autonomy as a central tenet of obstetrical decision making has been reinforced in both law and ethics.<sup>8</sup> However, the doctor has a professional duty to ensure no or minimal harm befalls their patient in the course of treatment. In this scenario, there are concerns that the planned caesarean delivery requested by the patient may pose more harm to her than a planned vaginal delivery in view of a long list of potential morbidities related to the surgery. In regards to cost of treatment, in a state-funded healthcare system, there is an ethical duty to society to allocate healthcare resources wisely to procedures and treatment for which there is clear evidence of a net benefit to health. On the other hand, the fiduciary duty to a woman is to favour her interest over the interest of others.

*Duty deliberation:* The physician should record and discuss the reasons for the request. Risks and benefits of the requested procedure should be discussed with the patient and assessment should be made to ascertain that patient is able to demonstrate an understanding the risks and benefits. Availability of health resources should also be considered in resource-limited areas.

*Testing consistency:* At present there is no hard evidence on the relative risks and benefits of term Caesarean delivery for non-medical reasons, as compared with vaginal delivery i.e. no evidence from randomised controlled trials upon which to base any practice recommendations regarding CDMR.<sup>9</sup> However, available evidence suggests that normal vaginal delivery is safer in the short and long term for both mother and child. Surgery on the uterus also has implications for later pregnancies and deliveries. At present, because hard evidence of net benefit does not exist, performing CS for non-medical reasons is ethically not justified.<sup>10</sup> However, while performing CS for non-medical reasons a decade ago was considered ethically not justified, recent guidelines seem much more supportive of women's choices.<sup>11</sup> In this patient, the risk posed by the current CS on her reproductive function i.e. subsequent pregnancies and deliveries is nullified as she will undergo sterilisation procedure at the same time. The Australian guidelines suggest that if after full discussion the patient persists with a request for delivery by CS, the obstetrician may choose to do one of the following: a) agree to perform the CS providing the patient is able to demonstrate an understanding the risks and benefits; b) decline to perform the CS in circumstances where the obstetrician believes there are significant health concerns for mother or baby if this course of action is pursued or the patient appears to not have an understanding sufficient to enable informed consent to the procedure, or c) advise the patient to seek the advice of another obstetrician for a second opinion.<sup>12</sup> The NICE document on CS recognises that a better approach than counselling women requesting CS about the risks would be to explore, record and discuss

the reasons for the request, thereby individualising cases and management.<sup>7,13</sup>

*Conclusion/Decision:* Caesarean section upon maternal requests can be performed if the patient is able to demonstrate sufficient understanding of risks and benefits of the procedure, including the long term risks, and the physician believes there are no significant health concerns for the mother and fetus and no issues regarding distribution of health resources if this action is pursued.

### Case 3

*A mother brought her 16 year-old daughter who has intellectual disability and requests for hysterectomy for her daughter. Her daughter has started menstruating one year earlier and has been experiencing irregular and heavy menstruation and has been unable to care for herself which has led to hygiene issues. The mother has been having difficulty in getting the child to take the medication prescribed. She is also concerned that her daughter may be sexually abused resulting in pregnancy as she has started to show keen interest in the opposite sex.*

Reasoning and ethical decision-making:

*Fact deliberation:* The parent of a child has made a decision for treatment of the child. There are issues regarding consent from the child due to the fact that the child is a minor and has intellectual disability hence assumed to have limited capacity to consent. Hysterectomy is a major surgical procedure that carries inherent risks and will affect the child's reproductive capacity. At the same time, it is also a definite solution to the problems related to menstrual abnormalities and unwanted pregnancies and for selected women, may improve the quality of life.<sup>14</sup> However, from the medical point of view, other treatment options which carry less risk to the child are also available.

*Value deliberation:* The conflict is between the autonomy of the mother in making decisions on behalf of her child who is perceived to be unable to make her

own decisions and respect for the right of the child to not be subjected to major procedures without her consent. The physician has the professional duty to ensure that the treatment is in the best interest of the child and to advise for a treatment which carries the least risks to the child.

*Duty deliberation:* The physician should discuss with the parent the risks and benefits of hysterectomy to the child and other available treatment options besides hysterectomy to achieve the desired result of cessation of menstruation and protection against unwanted pregnancies. Nevertheless, it is still prudent to assess the degree of mental disability of the child and the capacity to consent before the procedure is performed. The test for competence to consent should take a holistic approach by including other professionals such as nurses, sociologists, psychologists or even clergymen to play a part in order to determine the all-round competence of an individual for deciding or refusing treatment.<sup>15</sup>

*Testing consistency:* For any consent to be valid, it should be given by a competent person having the capacity to make the decision. According to Section 2 of the Age of Majority Act 1971 (Laws of Malaysia) a person is legally an adult when he or she reaches the age of 18. Before someone reaches this age of majority, consent for their medical treatment needs to be given by their parent or guardian except in the case of emergencies. Children with mental retardation are presumed incompetent just as all children are, as a matter of legal status. It is clear that from the legal point of view, the mother has a right to decide on the treatment for her child. However, The European Charter for Children in Hospitals states that children and parents have the right to informed participation in all the decisions involving their health care: 'Every child shall be protected from unnecessary medical treatment and investigation'.<sup>16</sup> Hence, whenever possible all attempts should be made to involve the child in the decision making and consent for the procedures to be undertaken.

In regards to the state of intellectual disability, it has been shown that in adults with mental retardation, depending on the severity of impairment, their treatment consent capacity varies considerably. In a study that compared mild (IQ 55–80) and moderate mental retardation (IQ 36–54) adults with non-mental retardation controls on treatment consent capacity for low-risk elective treatment procedures, most mild mental retardation adults' understanding and choice abilities were similar to those of controls, although they were significantly more impaired than controls on the appreciation and reasoning abilities.<sup>17</sup> These findings suggest that it would be important for children with mental disability to also be professionally assessed for competence in giving consent for treatment.

*Conclusion:* The mother is given an option for the child to have a progestogen-impregnated intra-uterine system insertion instead of a hysterectomy. To protect the rights of the child, she is to be assessed for competence to consent for the procedure by a multidisciplinary team.

## Discussion

We have chosen cases to illustrate that the problems or the clinical situations faced are often difficult from the moral point of view because there will be a conflict of values. Selecting one will usually result in infringement of the other values. A conflict of values can be solved in different ways, and the duty of a health provider is to identify and choose the one which promotes best the fulfilment of positive values, or that infringes least upon the values at stake.

We have also illustrated that to be able to arrive at wise decisions the health provider first and foremost needs to be professionally competent to offer medical advice on available treatment options, or to identify the experts in other clinical disciplines who can also contribute to patient care. Secondly, he or she should also be aware of the medical law and other guidelines available to help in the decision making. Advice from legal experts may be required in certain circumstances to ensure that the

decision made is within the limits of law of the country. Finally, when the first two components are satisfied, the ethical decision should follow. It can be seen that while the main goal is to arrive at an ethical decision, the fact that sufficient knowledge on the scientific component as well as the legal component is essential to enable a healthcare provider to arrive at a wise decision.

### Conclusion

The basic ethical principles of autonomy, beneficence, non-maleficence and justice are fundamental to good clinical practice. Practice guidelines may not provide sufficient information to resolve ethical dilemma. Physician-educators should be competent to use ethical decision models as well as best available scientific evidence so as to be able to arrive at the best decision for patient care as well as teach health professional trainees how reasonable treatment decisions can be made within the perimeter of medical law and social justice.

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### Box 1: The UNESCO Ethical Method of Reasoning

#### The UNESCO Ethical Method of Reasoning

- First Step: Fact deliberation
  - Analyse the case vignette
  - Deliberation about the medical facts
- Second Step: Value deliberation – identify moral problems and conflict of values
  - Identification of moral problems
  - Choice of the main problems
  - The values at stake
- Third Step: Duty deliberation – identify course of action
  - Reflecting on the most challenging cases
  - Reflecting on other cases
- Fourth Step: Testing consistency – guard against inconsistency by using the law and opinion of other experts
- Fifth Step: Conclusion – arrive at wise decisions