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ETHICS CASE

The Professional Responsibility Model and Patient Requests for Nonindicated Early Delivery

Commentary by Frank A. Chervenak, MD, and Laurence B. McCullough, PhD

Jane, at 37 weeks and 3 days gestation in her second pregnancy, is meeting with her obstetrician, Dr. Stevens, for a routine prenatal visit. As the visit is wrapping up, Jane mentions that, due to her work schedule, a week from now would be the best time for her to deliver, and she requests a labor induction during that week. Seeing the curiosity on Dr. Stevens' face, she says plaintively, "The baby is already full-term, right? Waiting longer is only going to make it harder for me to keep up with my job!"

Dr. Stevens agrees. "Yup, 37 weeks and beyond is considered full-term. You had an uncomplicated vaginal delivery last time, let's do it. We'll call once we get you on the schedule." At the end of office hours, he sits down to submit the scheduling request, but when he logs into his email, he sees a reminder email from the head of the quality improvement (QI) committee of the OB/GYN department at his hospital. The message reiterates the hospital's adoption of a policy that will bring the department in line with the recommendation by the American College of Obstetricians and Gynecologists (ACOG) against elective deliveries prior to 39 weeks.

Dr. Stevens realizes that scheduling this induction may become an uphill battle. In his low-risk practice at a community hospital, he has been offering labor induction for low-risk patients for nearly 30 years, and, when the QI committee first approached him about this initiative, he went so far as to complete a retrospective audit confirming that his outcomes have been comparable to those of other obstetricians working at that hospital. He feels strongly that the mother's request should be honored, and wonders what will be the best way to achieve this.

Commentary

The professional responsibility model of obstetric ethics is based on the ethical concept of medicine as a profession. Introduced in the late eighteenth century by the Scottish physician-ethicist John Gregory (1724-1773) and the English physician-ethicist Thomas Percival (1740-1804), this concept has three components. The physician should commit (a) to becoming scientifically and clinically competent, (b) to using his or her clinical knowledge and skills primarily for the clinical benefit of patients, systematically keeping self-interest secondary, and (c) to preserving medicine as a public trust and not a self-interested merchant guild, which it had been for centuries [1].

The first two commitments are directly relevant to the case. Physicians fulfill the first commitment, to scientific and clinical competence, by making medical decisions on the basis is of deliberative clinical judgment. Physicians fulfill the second commitment by focusing on high-quality patient care.

Deliberative clinical judgment aims to responsibly reduce uncontrolled variation in clinical judgment and practice based on it, thereby improving the quality of both. It should be based on the best available evidence and rigorous assessment of one's clinical judgment and practices to bring them into accord with the best available evidence. Deliberative clinical judgment should also be transparent—the bases for decisions made explicit rather than implicit—to prevent unacceptable shortcuts in clinical reasoning. Evidence-based, rigorous, and transparent deliberative clinical judgment, by its scientific and clinical excellence, creates accountability among clinical colleagues and trainees. Evidence-based clinical guidelines that are kept current with changing evidence support and guide deliberative clinical judgment and practice. Using such guidelines requires disciplined, not simple-minded, clinical reasoning.

Evidence-based clinical guidelines are essential for maintenance and improvement of the quality of patient care. Deliberative clinical judgment rules out elective induction before 39 weeks because it can result in iatrogenic neonatal prematurity, as well as an increased risk of an unnecessary cesarean delivery. Dr. Stevens therefore made a clinical error when he agreed to the patient's request for induction prior to 39 weeks. His first professional responsibility to the patient is to recognize that his own experience with induction before 39 weeks is not an adequate basis for deliberative clinical judgments about the benefits and risks of early induction, because of factors such as selection bias and the relatively small sample size. He therefore should follow the ACOG guideline and hospital policy based on that guideline.

To fulfill the second commitment of this ethical concept—applying his clinical knowledge and skills primarily for the clinical benefit of patients—requires that he correct the error of accepting the patient's request. He should do so by explaining to her that deliberative clinical judgment no longer supports induction before 39 weeks and that he will therefore follow the ACOG guideline and hospital policy.

The third commitment of the ethical concept of medicine as a profession—maintaining public trust in medicine—should be discharged by Dr. Stevens in the informed consent process. The professional responsibility model of obstetric ethics obligates the obstetrician to empower the pregnant woman to make decisions about her care. The obstetrician does so, first, by identifying all medically reasonable alternatives and presenting them to the pregnant woman. In obstetric practice, a medically reasonable alternative is one that is technically possible and, in deliberative clinical judgment, expected to benefit the pregnant, fetal, and neonatal patients clinically. A request for clinical management by a patient does not establish that form of clinical management as medically reasonable. Induction before 39

weeks, for the reasons explained above, is not medically reasonable and therefore should not be offered. If a pregnant woman requests this or any other form of clinical management that is not medically reasonable, the obstetrician should explain why he or she did not offer the requested management as a "reasonable alternative." This explanation constitutes the information without which the woman cannot make a truly informed decision—be it consent or refusal. Most patients lack the requisite expertise to interpret relevant evidence and make the best clinical judgment on their own. Supplying such information, followed by the physician's recommendation, empowers and therefore does not violate respect for the pregnant woman's autonomy.

The patient's request is understood in ethical reasoning to be a positive right: a claim on the resources, time, and effort of others to protect and promote her interests as she understands them. In ethical theory, positive rights are not absolute but come with limits; the only ethical question is what those limits are [2]. Deliberative clinical judgments about medical reasonableness justifiably limit a patient's positive right to treatment when the treatment requested is not medically reasonable.

In summary, it is not uncommon for pregnant patients to make requests that are not supported in deliberative clinical judgment and are therefore not medically reasonable. It is a clinical mistake to acquiesce to such requests. Dr. Stevens has made such a mistake, and he should correct this mistake by fulfilling the three professional responsibilities described above.

References

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