

Informed Consent: when autonomy & beneficence collide

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Objectives

- Autonomy & beneficence
- Culture of risk
- “Offer,” “recommend” or “coerce”
- The therapeutic alliance
- Fuzzy Logic
- What is “Informed Consent?”

Autonomy & Beneficence

- Autonomy:

- Beneficence:

Autonomy & Beneficence

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



- **Beneficence:** the imperative to do what is best for a patient

Autonomy vs. Beneficence

- **Autonomy:** an individual's right to decide their health care path

Whose values?

- **Beneficence:** the imperative to do what is best for a patient

Exploring Values

- Patient 'Values':
 - Religious beliefs
 - Emotional fears
 - Anecdotal experiences
 - Misconceptions
 - Individual circumstances
 - Patient preference
- Clinician 'Values':
 - Religious beliefs
 - Emotional fears
 - Anecdotal experiences
 - Misconceptions
 - Individual skills
 - Clinician preference

Objective, evidence-based, clinical judgment

“If there’s even a
1% chance of an
... act occurring,
we must treat
that as if it were
a certainty.”

(Dick Cheney, 2001)

Obstetrical Risks

- VBAC rupture causing NN 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 perinatal death:
 - Careful trial of labour: 1/500?
 - Elective C/S 1/1000

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:

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 accreta; previa; etc. unaccounted for

Recommend or Coerce?

- **Recommend**: endorse a preferred clinical course of action



- **Coerce**: compel by force of authority

Recommend or Coerce?

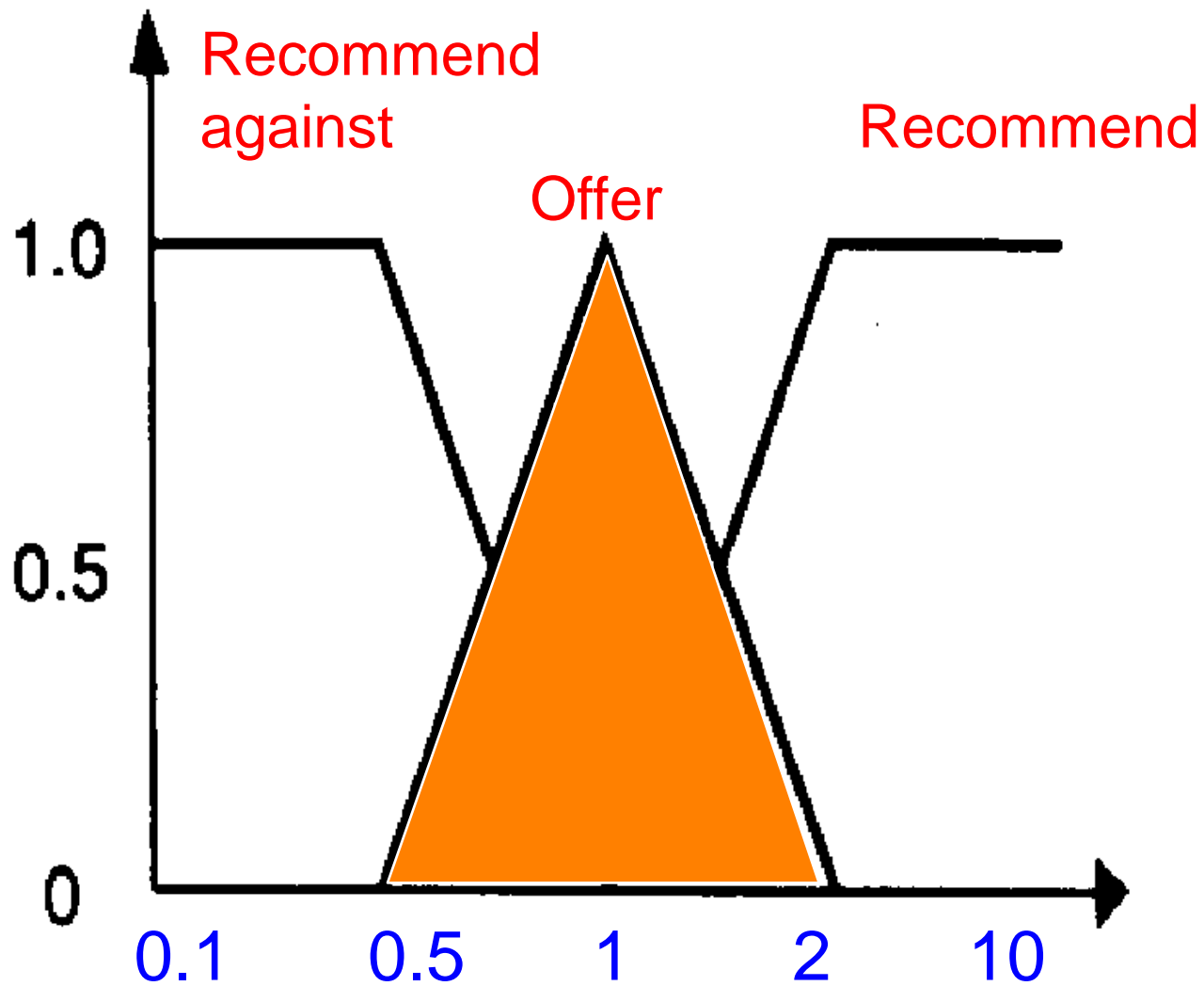
- **Recommend**: endorse a preferred clinical course of action

Autonomy – Honesty - Detachment

- **Coerce**: compel by force of authority

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 treatment = force natural Hx



Likelihood ratio: Benefit vs. Harm

Clear clinical direction:
“Recommend” vs. “Offer”



**Informed
Consent**

Patient
Autonomy

Emotional
detachment

A Clinician's 5 Choices

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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 < $\left\{ \begin{array}{l} \text{Beneficence} \\ + \\ \text{Non-Maleficence} \end{array} \right.$

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’ or ‘caring detachment’
(not an oxymoron)

Therapeutic Alliance

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

Therapeutic Alliance

“ I felt in control and taken care of.”

(Listening to mothers 2006)

Informed Consent

1. Pt understands the **diagnosis**
2. Pt knows the **natural history** 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 access alternatives and decline recommendations without prejudice**

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
- Only “offered” C/S - Client declines
- Midwife arranges consult with OB #2
- Only “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 transfer 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 for them?
- Could the midwife have done anything different?
- What is the difference between beneficence and non-maleficence?

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”

Autonomy?

“Pregnant women have beneficence-based obligations to the fetal patient to take *reasonable* clinical risks. When a clinical intervention is *expected* to benefit the fetal patient and there are not *unreasonable* clinical risks to the pregnant woman, she is ethically obliged to authorize and accept such an intervention.” (O & G 2011;117:1183–7)

Autonomy?

Who decides what is “*reasonable*” risk?

Who decides what degree of likelihood constitutes an “*expected benefit*”

Who decides what clinical risks are “*unreasonable?*”

Optimal Care?

“ ... in some circumstances the value and safety added by a physician’s participation *may* outweigh a potentially small increment in absolute risk that a particular patient choice carries.”

(Obstet Gynecol 2011;117:1179–82)

Key Points

- Autonomy trumps beneficence
- The therapeutic alliance is sacred
- Keep your values in perspective and your ego in your pocket
- Don't be afraid to recommend
- Don't take it personally if your recommendation is declined (and keep caring for your patient)