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Managing Conflicts of Interest: Perinatal Ethics in a Catholic Hospital

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As obstetrical caregivers, your ethical duty is simple and difficult at the same time. You are charged with the responsibility of providing the best possible care to each of your patients as dictated by the circumstances of each individual case. In fact, your responsibility is fiduciary to your patients. You act as their trustees, in confidence; with integrity, self-sacrifice, self-effacement, and compassion (1). You try to act in a beneficent manner, applying or recommending what you believe to be the best care in the patient's best interest. You respect the patient's autonomy, supporting her choice of care from among what you believe to be reasonable alternatives in a process of ethically informed consent. You try to be non-maleficent, providing care that is minimally harmful. You try to offer and provide care that is just, with attention to impartiality with respect to race, religion, and economic status, while being aware of the importance of conservation of limited resources. You try to balance the various interests involved in each case. You consider the patient's needs-based, subjective, deliberative, and social interests (2). You also weigh the interests of the family, society, third-party payors (2), and institutions such as the Providence Health System (3).

In almost all respects, the ethical duty described above is no different from that required of caregivers for pediatric or adult, non-pregnant patients. Pregnancy, however, presents the obstetrical caregiver with a dilemma that is still a matter of significant contention in the biomedical ethics literature. The controversy revolves around the question of the fetus as patient. If the pregnant mother with independent moral status presents to your office and requests care, she becomes your patient. When, however, does the fetus become a patient? McCullough and Chervenak (1) argue that the fetus has dependent moral status, dependent on the mother, and that it does not become a patient until it is viable and is brought to the caregiver by the mother for the care of both mother and fetus. They argue, as does Lyerly (3), that the previable fetus has no independent claim on the mother's care unless the autonomous mother so decides. Lugosi (4) and others disagree, arguing that the fetus has an independent claim to care from the moment of conception. They argue that a fetus has rights which may, at times, dictate care for the mother, for the benefit of the fetus, against the wishes of the mother.

It's difficult enough to try to resolve this dilemma in day-to-day practice in secular hospitals, but it becomes even more difficult in faith-based hospitals with moral institutional interests that would seem at odds with maternal autonomy. For those of you who practice in Catholic hospitals such as those in the Providence Health System, the dilemma of interests in conflict (e.g., maternal, fetal, institutional), is one you face daily. For those of you who practice in secular institutions without such conflicts, you may yet have to face these questions in the future as the Providence Health System gains more and more of the regional market share. A recent survey of Oregon and Southwest Washington hospitals showed that Providence Health System provides 35% of all deliveries currently (10,102/29,012) in the greater Portland-Vancouver metropolitan area.

How then to resolve such conflicts? Specifically, how would you envision balancing the interests of the mother, the fetus, and the church, while practicing in a Catholic hospital? If you are perhaps a "pro-choice" obstetrician with a strong commitment to maternal autonomy, you might be concerned that the ethical dilemmas posed above would strain relationships with patients, your hospital, and the hospital system at large. Hopefully though, you will feel supported and encouraged in providing what you believe to be the best care for your obstetrical patients. Hopefully you will not feel compromised or co-opted.

Hopefully, most of what you need to be done will get done, most of the time within the confines of the hospital, sometimes not.

The Ethical and Religious Directives for Catholic Health Care Services, 4th Edition, 2001 (hereafter referred to as the "Directives") (5) states "Catholic health care services must adopt these Directives as policy, require adherence to them within the institution as a condition for medical privileges and employment..." Further, they state "While the church cannot furnish a ready answer to every moral dilemma, there are many questions about which she provides normative guidance and direction. In the absence of a determination by the magisterium, but never contrary to church teaching, the guidance of approved authors can offer appropriate guidance for ethical decision making." (5) How to reconcile doctrine with practice?

The answer, in part, rests on a congruence of goals and mutual respect. Both caregivers and institution want to provide what they believe to be the best care for pregnant mothers. The institution respects the autonomy of the patients and the beneficence of the obstetrical providers and leaves the details of care to their ethically informed consent. The providers and patients, in turn, agree to respect and consider the teachings of the church as they relate to the case at hand. At Providence St Vincent Hospital, for example, when issues and relationships are in doubt, the Perinatal Ethics Committee, a subcommittee of the full St Vincent Hospital Ethics Committee, supported by the Providence Center for Health Care Ethics is called into the case for interpretation, guidance, and support. The following cases were chosen to illustrate the process as it translates to clinical decision-making and care.

CASE #1: An 18 year old G1 P1001 presents to the St Vincent ER, accompanied by a police detective. She gives a history of having been raped one hour previously. She asks for you to provide assistance to prevent pregnancy as a consequence of the rape. What can you offer her?

The Directives state: "A female who has been raped should be able to defend herself against a potential conception from a sexual assault. If, after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization. It is not permissible however, to initiate or to recommend treatments that have as their sole purpose or direct effect the removal, destruction, or interference with the implantation of a fertilized ovum." (5)

Here the operative word is "conception". If a pregnancy test is negative, the patient may be offered the full range of medications available to prevent subsequent conception.

CASE #2: A 23 year old G2 P1011 presents to the St Vincent ER with findings and history consistent with an ectopic pregnancy. What can you offer her?

The Directives state: "Abortion (that is the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted. In cases of extrauterine pregnancy, no intervention is morally licit which constitutes a direct abortion." (5)

Here the key phrase is "directly intended". Under the doctrine of "double effect", Catholic teaching considers a salpingectomy or salpingostomy in cases of ectopic pregnancy moral because the primary or direct intent in such cases was to control bleeding in the mother, not to perform an abortion. In such cases, the primary goal would be to save the life of the mother. The loss of the fetal life would be viewed as an unfortunate and unintended consequence of a moral act. (6)

CASE #3: A 32 year old G3 P1102 presents to labor and delivery at St Vincent at 19 weeks' gestation with premature rupture of the membranes, fever, elevated white count, and uterine tenderness suggestive of chorioamnionitis. What can you offer her?

The Directives state: "Operations, treatments, and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman are permitted when they cannot be safely postponed until the newborn child is viable, even if it will result in the death of the unborn child."

Here, the basis for institutional support is clearer. If the treatment can't wait until the child is viable, if a delay would harm the mother, then there would be no objection to treating the mother. Again the double-effect doctrine would be invoked. The treatment (i.e., delivery of the fetus, antibiotics) would be primarily intended to benefit the mother in a life-threatening situation, while the death of the neonate from prematurity would be the unintended and unfortunate secondary effect.

CASE #4: A severely hypertensive G4 P0303 requests a tubal ligation be performed after her fourth Cesarean delivery at 34 weeks' gestation. Is this possible, and if so, how?

The Directives state: "Direct sterilization of either men or women whether permanent or temporary, is not permitted in a Catholic health care institution. Procedures that induce sterility are permitted when their direct effect is the cure or alleviation of a present and serious pathology and a simpler treatment is not available." (5)

Here, the direct effect of the sterilization is the alleviation of the risk from future pregnancies of uterine rupture, placenta accreta, hypertensive complications, etc. The institution requests written justification of the proposed benefits (and thereby, direct intent) of the sterilization, and almost always responds favorably, also in writing.

CASE #5: A 38 year old G6 P4115 prior to her discharge from the St Vincent postpartum unit requests birth control pills. Is it possible to offer them to her and if so, how?

The Directives state: "Catholic health care institutions may not promote or condone contraceptive practices but should provide, for married couples and the medical staff who counsel them, instruction both about the Church's teaching on responsible parenthood and in methods of natural family planning." (5)

Here the operative word is "institutions". The obstetrical care providers are generally not employees of the institution, and as members of their respective professions, they may prescribe birth control pills as they wish.

CASE #6: A 23 year old G1 P0 at 32 weeks is carrying a breech fetus with extremely severe hydrocephalus resulting in a head that measures 11cm BPD at 30 weeks' gestation. The brain tissue has been almost entirely replaced with fluid. The obstetrical caregiver and the mother propose early delivery, to include draining of the fetal head prior to a vaginal delivery to avoid an almost certain classical cesarean and its inherent risks. How to proceed?

The perinatal ethics committee was called and given the facts in the case. They supported the proposed management with the reasoning that draining of the fetal brain was not intended directly to harm the fetus, in a situation where neonatal survival was highly unlikely and intact survival even less likely. They reasoned that the benefit to the mother was clear, as were the risks from classical cesarean section, now and in the future. The patient was admitted at 32 weeks, induced, and the fetal head was drained as planned. Not surprisingly, the fetus died during the vaginal delivery.

> Pregnancy presents the obstetrical caregiver with a dilemma that is still a matter of significant contention in the biomedical ethics literature.

In each of these cases, the decision-making revolved around relationships instead of rules. The goals were clear and they involved trying to provide patients with the best care, taking all of the above noted principles and interests into account. When ethical informed consent, negotiation amongst interested parties, and respectful persuasion did not bring about agreement, then the perinatal ethics team was called upon to provide guidance and support. Although the court system was available for adjudication of cases that defied the above, they were not utilized, a phenomenon widely reported in current ethics literature.

Institutions, however, have their limits, as do physicians and midwives. There are lines that neither institutions nor providers can cross. What that means for a future with perhaps no secular institutional alternatives in a specific geographical region is uncertain. It could certainly mean hardship for patients having to travel great distances to obtain certain types of care. Hopefully the above discussion will be helpful and applicable to those of you who practice in the Providence System. Unfortunately, not all Catholic and other faith-based hospital systems articulate their interests alike. Hopefully, however, the above discussion will be helpful to you as a study of process, and that it will translate to whatever the nature of the health care facility in which you practice.

References:

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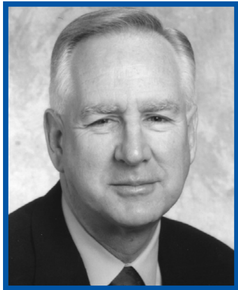
amniocentesis follow-up survey...

The genetic mid-trimester amniocentesis is a relatively common invasive procedure. The procedure-related pregnancy loss rate after amniocentesis is usually quoted at 0.5%. However, this figure is based on poor data. Recent studies have indicated that the loss rate is far lower than the 0.5% currently quoted. In an effort to establish our own complication rate, Northwest Perinatal Center will be conducting a survey of our patients regarding loss rate and complications following amniocentesis.

Starting January 1, 2008 patients will be asked a series of questions regarding post amniocentesis complications when they are called with their test results. Pregnancy outcome information will then be gathered following delivery for final data analysis. We hope this information will be helpful to both you and your patients.

We greatly appreciate your assistance with this project. If you have any questions please do not hesitate to contact us.

about the author...



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Dr. Watson was born in New York and raised in Philadelphia. He graduated from Williams College in Williamstown, Massachusetts and obtained his medical degree from the University of Pennsylvania School of Medicine. He completed his residency in obstetrics and gynecology at the University of Colorado, and went on to a fellowship in perinatology (high-risk obstetrics) at the University of Louisville in Kentucky.

While in medical school, Dr. Watson met and married his wife, Harriet. Their family includes two grown sons, David and Eric. Dr. Watson's recreational interests include soccer, skiing, fly fishing, and golf.

As Oregon's first community perinatologist, he established the Emanuel Perinatal Center in 1979, and in 1992 founded the Northwest Perinatal Center at St. Vincent's Hospital.

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