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Patient Requested Induction of Labor – Examining an Ethical Dilemma

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Patient Requested Induction of Labor – Examining an Ethical Dilemma

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Abstract

Induction of labor when the cervix is not ready or ripe often leads to cesarean section. There is evidence that a significant number of inductions have no medical indication and that women's requests for induction are contributing to these rising numbers. Midwives have historically included women in the delivery decision-making process while priding themselves on the use of evidence-based research when making clinical decisions. In this manuscript, an ethical dilemma is examined with respect to patient requested induction of labor and ways to arrive at a clinical decision that includes ethical theory, clinical presentation and the complexities of the individual.

Key words: elective induction of labor, ethics of induction of labor, birth outcomes, clinical decision-making, patient requested induction of labor

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THE CASE STUDY

The patient is a 21year old gravida 1, para 0 who presents at 39 weeks gestation for her prenatal appointment. She explains that she would like to be induced the following day because her grandmother is having surgery in four days and the prognosis "is not good". She would like her grandmother to see the baby prior to surgery. She and her immediate family are worried her grandmother may be critically ill and may not survive the surgery. The patient's chart is reviewed. The patient is found to have no previous contributory medical or surgical history. Her prenatal care began at 10 weeks from her last menstrual period. All routine laboratory tests and ultrasounds have been normal. Her weight gain, blood pressure and fundal growth have also been within the expected range. She and her supportive boyfriend have attended childbirth classes and she presented her birth plan to the midwife last week. She would prefer to labor in the tub but is open to an epidural if needed. Her support network includes her mom and aunt and sister who accompany her for prenatal care as often as they can. Today her visit is completely within normal limits. She seems worried and fearful when speaking about her grandmother's upcoming surgery. She is adamant that she wants the baby to be born within the next couple of days. Her boyfriend, mother, sister and aunt are present and in agreement that the birth should not be delayed.

INTRODUCTION

The practice of midwifery is based on relevant and sound research findings. Evidence-based research is used to make clinical decisions in simple scenarios, as well as more complex ones such as the case that has been presented (ACNM, 2010). Midwifery as a profession is known for providing compassionate care and advocating for women to partner and participate in their care. Midwives respect an individual's right to birth as they wish and at the same time advocate to improve childbirth statistics, which include cesarean section

rates and the number of late preterm births. Midwifery care of women, while relying on scientific evidence, also focuses on the woman as an individual and what her unique needs are (ACNM, 1989). The conflict of how to provide care that reflects a woman's unique needs and her desires, yet does not put the woman and her baby at increased health risk is apparent in this case study.

This conflict is an ethical dilemma, which is defined as being in a situation of having to choose between two equally dissatisfying solutions to a problem that concerns two ethical principles (Beauchamp, 2009). In this case, the ethical principles in conflict are autonomy and nonmaleficence. Autonomy is the principle that addresses the individual's right to self determination and choice. Nonmaleficence is the principle of not doing harm (Beauchamp, 2009). The process of making the best clinical decision in this ethically challenging case involves examining several areas which include ethical models and theory, the patient's clinical picture and individual needs, and scientific research.

A MODEL OF BIOETHICS

It is important when a conflict is identified that midwives embark on a process that leads to a decision that is ethically sound through careful deliberation. Having a model to refer to can help to structure the decision-making process and guide the midwife through a series of questions and elements of the dilemma so that the process is thorough and complete. The Thompson and Thompson bioethical decision-making model (Thompson, 2004) will be used in this article to deconstruct the case that has been presented. Joyce Beebe Thompson, one of the authors of this model, is a midwife and a major contributor on the subject of ethics and health care (Thompson 2004).

The Thompson and Thompson bioethical decision-making model (T/TBDM) has ten steps (Thompson 2004.) In Table 1, Step One includes reviewing the situation in terms of the health problem, the time element, any human rights violation, and the

ethical considerations. In this case study, to the patient requesting an induction of labor, time is really of the essence – her grandmother's surgery is in three days. Step Two involves gathering more information which may help in the decision-making process such as institutional policies and decision-making capacity. Checking practice and hospital guidelines and protocols, as well as guidelines developed by the American College of Midwives and American College of Obstetricians and Gynecologists is an important part of this step. Step Three consists of identifying the ethical issue. In this case the ethical issue is whether elective induction of labor will be harmful or will be of benefit. In Step Four, the midwife defines her/his moral position concerning the problem. It is important for the midwife to examine her/his beliefs and opinions about patient requested induction of labor. Step Five's focus is on examining the moral development of the persons involved in the problem. Step Six consists of identifying any value conflicts with involved parties. Is the midwife committed to one philosophy of management and the family or other providers in disagreement with her/him? In Step Seven the midwife determines who should make the decision. In this case, the decision-maker could be the midwife, the patient and family or even the consulting physician. Step Eight's focus is on identifying the moral and ethical justification and theory attached to the decision. Identifying what theory is in play here is an important step because it helps to raise the awareness of how one's ethical principles can influence decision-making. Step Nine is making the decision - to induce labor or wait for spontaneous labor - and Step Ten is evaluating the decision in terms of expected outcomes, fairness and what was learned by the action taken. Whether the decision was to induce labor or wait for spontaneous labor, it is important to reflect on what were the benefits, what were the risks, and what were the potential risks along the way towards the end result (Thompson, 2004).

THE THOMPSON AND THOMPSON BIOETHICAL DECISION MAKING MODEL

Step One	Review the situation to determine - health problems, actions needed immediately, ethical components, individuals affected by the decision, potential for human rights violation.
Step Two	Gather information to clarify - legal constraints, decision making capacity, institutional policies, values in the choice of information.
Step Three	Identify the ethical issues–name the ethical concern, explore the historical roots, identify philosophical, religious, cultural views .
Step Four	Define personal and professional moral positions on ethical concerns.
Step Five	Identify moral positions of key individuals in the situation.
Step Six	Identify value conflicts.
Step Seven	Determine who should make the decision.
Step Eight	Identify the range of actions with anticipated outcomes of each.
Step Nine	Decide on a course of action and carry it out.
Step Ten	Evaluate/review outcomes of decisions and actions.

Table 1
Printed with permission from the author, Joyce Beebe Thompson, CNM, DrPH

THE DECISION MAKING PROCESS

Examining the Evidence

In Step One (Table 1), Thompson refers to the importance of looking at the data. What are the actions? What are the choices available? What are the consequences of the proposed action and who will be affected by the action? The action in this case is to induce labor without a medical indication. The woman and her baby are the key players in this scenario that will be affected by the interventions needed to induce labor. This is what is known about the consequences of elective induction of labor: Elective induction of labor nearly doubles the risk of cesarean birth in nulliparous women (Cammu, H., Martens,G., Ruyssinck,G., & Amy, J., 2002). With surgery comes increase risk of complications due to infection, blood loss and anesthesia, as well as additional post operative recovery time. The increase risk of cesarean birth is related to an induction of labor with an unfavorable cervix. (An unfavorable cervix is one which has a bishop score less than or equal to five (Wing,

2005)). The patient in the case study has a bishop score of one. Near term infants (NTI) are infants that are on the cusp of lung maturity. Their numbers are increasing in the NICU for respiratory problems and elective births are responsible for many of these admissions (Buus-Frank, 2005). Often, dating of pregnancy may not be exact enough to know which infant will meet the NTI criteria. From 1992 to 2002, in the United States, there was an increase of babies born whose gestational age was 34-39 weeks, with the largest proportion (74%) of preterm births being late preterm births (34-36 weeks). During that same time period, births with medical interventions also increased (Davidoff, 2006).

Induction of labor increases a woman's need for analgesia and epidural anesthesia. It limits her mobility, she is often kept without food, and may need a foley catheter. There needs to be some thought about the possible post partum experience of a woman whose labor experience consists of being confined to a bed, without oral fluids and unable to urinate on her own. In a survey of 1,573 new mothers given the Post Traumatic Stress Disorder Symptom Scale (PTSD), it was found that 18% of those women suffered from some PTSD symptoms and 9% met all the criteria for PTSD (Delereq, Sakala, Corry, & Appelbaum, 2008).

Sakala and Corry looked at data of 31,000 induced births in a ten year period and found that there was no apparent reason for 25% of them. They also note that 19% of inductions were done because the woman wanted to end the pregnancy. Based on this information, it seems that a significant number of labor inductions, which are not evidenced-based, begin with a woman's request and/or without a medical/obstetrical reason (Sakala & Corry, 2008).

There has not been research to support elective induction. There is not enough evidence to conclude that elective induction is as safe as spontaneous labor or that it can be

practiced with confidence that there will not be an increase risk of significant maternal or fetal morbidity.

The American College of Nurse Midwives' (ACNM) position statement on the appropriate use of technology in childbirth says that when interventions are used, the benefits of the intervention should outweigh the risks. Their "Share with Women" document on induction of labor for the consumer states that induction of labor is a "bad" idea if the baby and mother are healthy (Share with Women, 2008).

The Individual and Practice Policy

Midwifery care of women, while relying on evidence, also focuses on the woman as an individual and what her unique needs are. With this case in mind, the midwife needs to collect data on this woman's emotional health. She/he needs to know if she has a history of depression or has had psychological counseling in the past. The midwife also needs to know what is the current emotional state of her/his patient and what would be the effects of the loss of her grandmother prior to the birth of the baby on the patient's mental well being. The midwife needs to think about whether the bonding experience with her newborn and her confidence to mother her child would be jeopardized. This is important information that requires time and attention. In this case the woman did not have a psychiatric history, but she was clearly very anxious about her grandmother's upcoming surgery.

Step Two of the T/TBDM (Table 1) includes reviewing institutional policies and decision-making capacity. The midwifery practice providing care to this woman did not have written guidelines with respect to patient requested induction of labor nor did the hospital. The practice philosophy historically was not to induce labor unless there was a medical indication. There were no hospital or practice statistics available to refer to help make a decision for this patient.

Ethical Theory

Step Three of the T/TBM (Table 1) is to examine the ethical considerations of the case. Mila A. Aroskar's classic model for examining an ethical dilemma includes looking at ethical theory not to solve a dilemma but to help clarify the dilemma (Aroskar, 1980). Identification of the ethical theory in use in this situation is important because it helps to raise the consciousness of the midwife as to what process and outcome she/he thinks is important and why. Egoism is in play here if one holds fast to the principle of practicing only what one considers evidence-based care without taking into consideration the woman and her wishes. If one's theoretical foundation is utilitarian then one believes that what is important is looking at all the benefits and risks and coming to a decision that seems best for everyone concerned (Aroskar, 1980). Thompson, in her model (Steps Four and Five (Table 1)), refers to the process of moral reasoning that she recognizes is very similar to the process of midwifery care. The process includes "analyzing, weighing, choosing, justifying, and evaluating competing reasons for taking action" (Thompson, 2004). In Step Four of the T/TBDM, she suggests one defines personal and professional moral positions on ethical concerns (see Table 1). Who the midwife is in terms of how she/he views life and the world through an ethical lens plays an important part in the process of resolving this ethical dilemma. In the above case the midwife caring for the woman revealed that utilitarianism was the ethical theory with which she identified. She wanted to make the best decision for all concerned – the woman, the baby and the grandmother, as well. The value conflicts (Step Six (Table 1)) became apparent when the midwife's initial reaction to her patient's request was to say no and argue the benefits of spontaneous labor versus the risks of induction of labor without a medical indication.

The Decision Maker

Thompson, in Step Seven, asks the questions "who owns the problem/decision?" In this situation, the decision could be made by the woman, the family, the clinician or the entire

team. The ethical principle of autonomy requires that the wishes and desires of an individual be respected. Midwives are advocates for women and always have been. Both the ACNM and the International Federation of Midwives (ICM) in their code of ethics speak to how midwives encourage women to make informed decisions (ACNM, 2005, ICM, n.d.). The ICM code of ethics says, "Midwives respect a woman's informed right of choice and promote the woman's acceptance of responsibility for the outcomes of her choice" (ICM n.d.). With regards to this case study, it then might be considered unethical for a midwife not to support this woman's desire for an induction of labor, especially if she is informed of the risks and benefits and has demonstrated a healthy decision-making capacity. Not regarding the right of a woman to make informed choice with regards to induction of labor can also be seen as paternalistic (Minkoff, 2006). Are health care providers placing their values above those of their patients if they refuse the patient's request? The American College of Obstetricians and Gynecologists (ACOG) include logistics such as history of rapid labors and distance from the hospital as valid reasons to induce labor (ACOG, 2006). There does exist an argument which says that some women are unaware of how childbirth, through the medical model, has been a slow and at times a covert evolution away from feminism. Is patient requested induction of labor an example of women's autonomy or, is it as some critics argue, a "gender based discrimination?"(Bergeon, 2007). Midwives should consider the answer to this question when faced with the ethical dilemma of patient requested induction of labor.

Midwifery care includes considering all aspects of a woman's life. In an ethical dilemma there needs to be consideration of what is at stake clinically, emotionally, ethically and professionally. What are the future ramifications not only for the woman (increased risk of cesarean section leads to repeat cesarean section which leads to increased risk of placenta accreta) but for one's practice and practice trends of a community and a country?

RECOMMENDATIONS

Research is needed to examine the safety and benefit of elective induction when compared to spontaneous labor and birth. Until then midwives and other health care providers do not have any data that supports patient requested induction of labor as a practice that is as safeor safer than spontaneous labor and birth.

There has been much written concerning the ethics and practice of patient requested cesarean section. Consumers, feminists, midwives and physicians have written on this topic (Davidoff, 2006; Minkoff, 2006; Bergeon, 2007; Potter, 2008). There needs to be equal attention paid to decision-making about elective induction. This discussion should be taking place on editorial pages of journals, within provider meetings and during hospital departmental meetings. There needs to be the same thought process and approach to the situation as there would be to any challenging clinical or ethical dilemma – consideration of the scientific evidence, the clinical picture and the complexities of the individual who sits before the health care providers.

PATIENT REQUESTED INDUCTION OF LABOR

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CLINICAL PICTURE + RESEARCH + ETHICAL THEORY +

INSTITUTIONAL GUIDELINES + THE INDIVIDUAL

⇩

THE DECISION

RETURNING TO THE CASE

The patient had an induction of labor the day after her prenatal visit during which she expressed her wishes to be induced. The decision was made after much conversation with her and her entire family about the risks and benefits. Her sense of urgency, the collective sense of urgency of the entire family and level of emotion surrounding the grandmother's

state of health were the deciding factors. In this case, autonomy weighed heavy and won. She had a long, three day induction which included cervidil, pitocin, an epidural and a foley catheter. During the second day she and her family requested a cesarean section but were denied due to there being insufficient obstetrical evidence for one. She went on to have a normal spontaneous vaginal delivery of a healthy baby. The delivery was complicated by a post partum hemorrhage which was quickly resolved. She and the baby were discharged on the morning of her grandmother's surgery. Her grandmother was able to see the baby prior to surgery.

Although the outcome of this case proved to be of benefit to all concerned the potential risks of the decision weighed heavy in the minds of the attending midwives throughout the three day induction. The potential for neonatal and maternal morbidity secondary to chorioamnionitis, arrest of labor and cesarean section were ever present. The fear of having made the wrong decision and "doing harm" was apparent in every clinical decision made during her labor. In evaluating the outcome (T/TBDM Step Ten (Table 1) it could be said that even though this decision was made with care and with respect to the woman's autonomy and emotional well being it was a decision that could have had results that were not the best for the baby and woman. Having a decision-making model to refer to when confronted with an ethically challenging clinical case is helpful for the midwife. It guarantees that the decision will be made with thought and careful deliberation. It does not guarantee that the decision will always have the most satisfying results.

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