case study

Birth Plans and Professional Autonomy

Ms. G is twenty-six years old, single, insulin dependent diabetic, and pregnant with her first child. Using information from the Internet and her midwife, Ms. G has developed a five-page birth plan that stresses her desire for a natural birth process and refuses, among other things, pain medication, fetal monitoring, episiotomy, and either forceps or vacuum delivery. Her midwife referred her to University Hospital's Maternal-Fetal Medicine Group in the thirty-third week of pregnancy because of unstable blood sugar levels and because her fetus was large for its gestational age. Ms. G was upset about the transfer, but trusted her midwife's judgment.

During Ms. G's first visit to the clinic, Dr. A explained that they would be monitoring the baby with the plan to induce labor as soon as the lungs were mature. Dr. A was uncomfortable with Ms. G's birth plan. She explained the potential benefits of monitoring, episiotomy, and instrument-assisted delivery with pain medication. If labor is delayed or the baby gets stuck, these tools can help effect a safe delivery. Ms. G was not convinced. She did not believe that the procedures were ever warranted. Dr. A was not happy with the conversation but did not pursue it and attached a copy of Ms. G's plan to the patient chart. Ms. G saw a few more members of the team during the next four weeks, but those visits consisted mostly of blood draws, an ultrasound, and exams.

No one else discussed her birth plan with her until she was admitted to the hospital in her thirty-eighth week for the planned induction of labor. Dr. A was there to begin the induction. Ten hours later, Ms. G had not yet delivered, and Dr. B, who had never met Ms. G, relieved Dr. A. After looking at the birth plan, Dr. B said, "I cannot follow this in good conscience. You are asking me to act against my training. You and your baby could die."

Now in active labor, Ms. G continued to refuse. Dr. B then said, "If you don't allow me to use these tools if needed, then I think you need a C-Section because the risk is too great to you and your baby." Crying that she didn't want a C-Section, she reluctantly consented to the use of monitoring, episiotomy, forceps, and vacuum if needed. She vaginally delivered a healthy, 4,000-gram boy. Her episiotomy healed without complication.

commentary

by Constance Perry and Linda Quinn

The dilemma portrayed here between patient and professional autonomy developed out of deeper problems of communication and a pervading atmosphere of distrust. Ms. G distrusts the obstetricians who represent the technological approach she tried to avoid. The obstetricians distrust the patient because she is asking them to practice against their training and professional judgment.

The patient's birth plan is the product of an inadequate informed consent process. While health care professionals want patients to become educated about their conditions and potential treatment options, that education is not a substitute for ongoing discussion about treatment options. In this case, the midwife should have initiated, as part of the development of the birth plan, a discussion of Ms. G's goals in light of some of the predictable complications of a diabetic pregnancy and the associated treatment options. That discussion could have provided a foundation for the obstetricians to build on when Ms. G was transferred to their service. Such discussions should have continued throughout Ms. G's care.

Besides a discussion of treatment options, Dr. A should have explained to Ms. G how this group practice works, including any consensus on practice standards and the possibility that Dr. A might not be present for the entire delivery. In a large practice, it is not possible for each obstetrician to meet and speak with each patient. Yet the patient should be assured that her treatment agreement with one doctor would be honored by others. Such assurances can become very difficult in large group practices. In the case of a planned induction, however, the obstetricians who might be involved in a delivery can be identified fairly accurately. They can be apprised of the patient's treatment wishes and given the opportunity to transfer her care to someone else. As other

physicians become involved, they may seek further discussion with the patient about her care, but the patient should not be badgered into changing her treatment with each shift change.

A frank and compassionate discussion between the patient and the physicians about the birth plan was needed. While Ms. G has a right to refuse any treatment, and while mere professional preference is insufficient reason to override a woman's treatment preference, it is unfair to require physicians to practice contrary to the minimal standards of their training and yet hold them accountable for bad outcomes.

If the patient and the treatment team could not come to an agreement, transferring her care to another team might have been an option. If not, then the team needed to respect the patient's informed refusal. The risk from infringement on autonomy is greater for the patient than the professional, and the fetus cannot be treated without breaching the woman's body. To limit the infringement on professional integrity, however, the obstetrical team should be provided protection from prosecution for complications that arise from the refusal.

Developing trust is essential. Dr. A needed to provide Ms. G with a reason to trust her judgment, as did each member of the team involved in Ms. G's care. Similarly, Ms. G needed to provide the physicians with reasons to trust her judgment. Trust requires mutual respect and willingness to listen. Discussion is the best tool available to foster trust, show respect, and promote the autonomy and integrity of all involved. The institutional factors must be in place, however, to make such conversations possible.

commentary

by James Lindemann Nelson

In the mid-1970s, Tom Conti starred in *The Glittering Prizes*, a vaunted BBC miniseries that followed a group of bright young things from undergraduate glories at Cambridge through various stages of their lives. Early in the story, Conti's character Adam visits the stately country home of an aristocratic friend who, like Adam, had abandoned religious observance under the influence of an aggressively secular strain of Cambridge philosophy. Adam's friend is terminally ill, though he doesn't yet know it. Among his guests is also a priest, summoned by the young man's parents to gather in his soul like a ripe fruit just as it falls off the twig. Adam was eloquently enraged that the priest was willing to take advantage of his friend's vulnerability. The priest was politely imperturbable.

Ms. G seems to me to be caught up in a similar situation, though if anything, she's even more vulnerable than Adam's friend. She lacks anyone to provide a supportive stream of indignation as she tries to enforce her agreement while in active labor and in the face of someone who insinuates that her options are to toe the line or submit to the knife. Where oh where did her midwife go? Why wasn't she there when Ms. G first opened up negotiations with Dr. A? Why isn't she there now to advocate for her client? For that matter, where is the person who impregnated her, who also might provide some helpful resistance?

For some kind of counterpressure surely seems needed. Dr. B's first act out of the gate is to conscientiously object to the whole deal. This is going straight for the big guns—the resort to conscience is one of the most powerful in the rhetoric of morality, and it's often persuasive. How *could* Ms. G. importune Dr. B to be a part of something that goes against his professional training?

Yet appeals to conscience aren't always dispositive, and in this instance, it's worth wondering whether Dr. B's conscience mightn't be ill formed. At what point should B's commitment to respecting a patient's informed decisions about what will and what will not invade her body (surely, that too was part of B's professional training) give way to the conscientious commitment to preserve the lives and health of the patient and her child? How serious must the threat to one commitment be before the other gives way? And is the decision properly a matter of just how it happens to strike Dr. B?

Like the self-assured priest, Dr. B does not act like someone who faces an excruciating problem. We don't see Dr. B working hard to mediate the dilemma between respecting this woman's wishes and protecting life and health. Is that because the risks to mother and child are too clear, too present, and too enormous? Assuming good faith on Dr. A's part, it seems that they were acceptable to at least one specialist in maternal-fetal medicine.

No doubt, everyone involved should have done more talking at the start. Maybe Ms. G had some factual misconceptions that further discussion would have unearthed and resolved. Maybe the fact that Dr. A couldn't guarantee being present for the entire birth would have emerged. Dr. B (and perhaps Drs. C, D, and E as well) should have been put in the picture and given an opportunity to voice his scruples. But the fundamental problem here is not so much a lack of communication as a clash of worldviews, coupled with the confidence in one's own rectitude that allows you to take advantage of a supine opponent. Ethnographic studies on women who try to tailor medicine's involvement in their birthing to fit their own hopes for the experience suggests that matters tend to turn out this way rather often; lots of discussion beforehand and carefully negotiated treaties don't turn out to be altogether reliable. (See Elizabeth Bogdan-Lovis's work in *Michigan Feminist Studies* 1996-97.) Such research indicates that people like Ms. G need more than discussion; they need doctors who take with deep seriousness what they want, even if those desires represent medical heresy. Without doctors whose consciences recognize the value of their patients' aspirations, the next best thing for the Ms. G's of the world might be to invite some articulate and assertive friends along.

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