Ask a Lawyer

In the Patient's Best Interest: Informed Consent or Protection from the Truth?

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Abstract

In response to a reader's essay, the author of this column states that physicians must legally and ethically provide expectant parents with information about their risks and options. It is not acceptable to withhold information or simply not to bother to relate information. Childbirth educators can help promote patient autonomy in health decision-making.

Journal of Perinatal Education, 9(3), 44–47; *childbirth educators, legal responsibility, ethical responsibility, patient autonomy.*

Editor's Note: A reader recently submitted the following essay, titled "The Ostrich Principle." Because the piece brings up the question of ethical care, we have asked our columnist, Nayna Philipsen, to add her own response following this essay.

The Ostrich Principle

I recently talked with an expectant father of twins who was assisting his morning-sick wife by scheduling their prenatal education classes. In the course of our conversation he told me that they were changing obstetricians. When I asked why, he said that their prior doctor was too laid back and noninformational for their needs. Their questions were typically answered with the phrase, "You don't need to worry about that." When the couple had asked about attending a special multiple birth class, the doctor discouraged them, saying that it would cause them anxiety over things they just did not need to worry about.

While the doctor's "burying-your-head-in-the-sand"

viewpoint may reflect a personal philosophy, this type of thinking certainly doesn't meet the needs of today's consumer. Expectant parents are more educated and have greater information needs than ever before. Consumers are encouraged to be proactive and preventive, and to take charge of their own health care. To do this, much of the information they need is as close as the computer mouse at their fingertips. But being proactive also means learning about possible health risks—something that might produce anxiety, if not given the proper tools.

Over the past 8 years, I have had the privilege of teaching and advising more than 1,200 expectant parents having twins, triplets, quadruplets, and even quintuplets. Many have had extensive experience with infertility technology and are quite aware of the task ahead with a multiple pregnancy. It is no secret to these parents that having more than one baby involves risk. They have read about the successes and failures of septuplets and octuplets, and they are hungry to learn how the risks apply to their own pregnancy.

I teach these families a blend of what they *want* to know and what they *need* to know. In addition to the fun facts about numbers of diapers and the kinds of strollers for twins, these families also discover the challenges of a high-risk pregnancy. They learn about adequate calorie intake and weight gain, and how to modify their fast-paced lifestyles. They also learn about those aspects of pregnancy that they don't have control over, such as preterm labor, hypertension, twin-to-twin transfusion, and the greater likelihood of cesarean birth. They learn the statistics, warning signs, and symptoms, and how complications are managed. Hopefully, early recognition will lead to earlier treatment and better outcome.

By conveying a combination of information and practical coping tools, difficult subjects don't have to be overwhelming. For example, preterm labor is the greatest risk in multiple pregnancy: Over 50% of twins are preterm and weigh less than 2,500 grams at birth. Those are scary statistics, and expectant mothers might be prone to dwell upon them. But a recent study[1] showed that relaxation therapy makes a difference in preterm labor outcome for at-risk pregnancies. Women in the study group who used a relaxation program had longer pregnancies and heavier babies than women in the control group. Teaching relaxation thus becomes an effective tool not only for coping in labor but for improving pregnancy outcome.

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Another effective tool is simply to clarify misinformation. Twin-to-twin transfusion is a serious problem that many parents having twins worry about. I often hear sighs of relief when they learn that it is not a risk for all twins, only those that share a placenta.

The ostrich principle of "knowing too much might upset you" is a first cousin to "what you don't know won't hurt you." Should we forego breast self-examination because it makes us think about breast cancer? Do we stop teaching infant CPR because parents might worry about their baby dying of SIDS? Does teaching about preterm labor cause women so much anxiety that it becomes a self-fulfilling prophecy? We all know the answers. As perinatal educators we are in unique positions to offer expectant parents information in ways that empower them. We are their advocates and we cannot allow the ostrich principle to rule.

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[1]Janke, J. (1999). The effect of relaxation therapy on preterm labor outcomes. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 28*(3), 255–263.

"Ask a Lawyer" Responds

This essay brings to light one of the essential rights and responsibilities of health care—*informed consent*. Every individual has a traditional common-law right to control his or her own person. "No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his person, free from all restraint or interference of others, unless by clear and unquestionable authority of

law."[2] It is also a fundamental liberty interest protected by the 14th Amendment to the U.S. Constitution. In 1990, Congress enacted the Patient Self-Determination Act (Omnibus Budget Reconciliation Act). The intent of this federal law is to assure that citizens get information to help them assert their autonomy in health decision-making, even if they later become incompetent. An incompetent person is one who is not able to make responsible decisions, for any of a number of reasons: infancy, handicap, or medications that alter perception and/or communication. Pregnancy does not create incompetence![3]

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Physicians should be aware that, in addition to laws protecting individual autonomy, their state medical practice act and the American Medical Association's Code of Ethics require them to provide patients with full information and to honor patient decisions. Failure to do so in some circumstances would also be a medical malpractice. The AMA Code of Ethics at Opinion 8.08 states in part, "The patient's right to self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The patient should make his or her own determination on treatment. The physician's obligation is to present the medical facts accurately to the patient or to the individual responsible for the patient's care and to make recommendations for management in accordance with good medical practice."

Sometimes a physician or an educator decides that certain information may be uncomfortable or distressing to a patient. He or she may conclude that the patient should therefore be "protected" from that information. Whatever the reason, this practice deprives the patient of the ability to make health choices and, instead, substitutes the choices of the professional. Nancy Bowers describes one example in "The Ostrich Principle." It is commonly called *paternalism*. A physician who believes that his or her patient cannot handle information cannot deprive that patient of such a basic right without going through procedures designed to protect autonomy, such as consultation with hospital ethics committees or even a court hearing. Paternalism is seldom a legal or an ethical excuse for a physician or other caregiver who has avoided addressing difficult issues with a patient.

AMA's Principles of Medical Ethics require that a physician respect both human dignity and the law. Out of six "Fundamental Elements of the Patient-Physician Relationship" identified by the AMA, the first two deal with information and autonomy. Number One states, "The patient has the right to receive information from physicians and to discuss the benefits, risks, and costs. . . ." Number Two states, "The patient has the right to make decisions regarding the health care that is recommended by his or her physician. Accordingly, patients may accept or refuse any recommended medical treatment."

Physicians today must provide expectant parents with information about their risks and options. It is not acceptable to withhold information or simply not to bother to relate information, as in, "Oh yeah, I forgot to tell you that you have a 50% chance of delivering preterm."

Since the patient must ultimately make all health care decisions, the right to all the information that she/he reasonably needs to make those decisions is paramount. As perinatal health care becomes more complex, expectant parents need information about these complex issues.

Our couples are best served by complete and candid information from their physician and from their educa-

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[2]See Union Pacific Railroad Co. v. Botsford, 141 U.S. 250 (1891).

[3]For further discussion on the Doctrine of Informed Consent, see the "Ask a Lawyer" column on pages 49–50 in the Volume 9, Number 1 (2000) issue of *The Journal of Perinatal Education.* That column is titled "Childbirth Educators' Legal and Ethical Responsibilities to Women in Labor."

tors. Childbirth educators and physicians are on the same team in providing instruction to patients about the health care decisions that they will make in pregnancy and during birth. Physicians and educators share the goal of caring for couples who make intelligent choices. Physicians should be able to assume that their couples who attend childbirth classes have been offered a core of knowledge (in the form of discussion, films, Lamaze magazines, and other printed matter) that will assist them in communicating about medical decisions during pregnancy and birth. Childbirth educators should be able to share their course outline and list of videos and handouts with health caregivers to request their feedback on what information patients need. Educators should also be able to tell couples to "ask your doctor" when medical questions arise, knowing that the couples will get an accurate and thoughtful response.

"Ostrich" author Bowers addresses concerns for the special needs of a selected group—parents with a multiple gestation. Other special-needs groups often identified by childbirth educators include teenagers, cesarean mothers, vaginal-birth-after-cesarean mothers, drug addicts, and mothers who have had previous fetal loss. Ms. Bowers is absolutely correct in her argument that caregivers and educators must tailor instruction to identified special needs. She is also correct in advocating for her students.

Unfortunately, not all physicians or other caregivers meet legal, ethical, or practice standards. What can you, the educator, do if you think you have identified an unacceptable practice? There are a number of strategies to pursue in order to seek change and protect patients. Often, more than one strategy is appropriate. First, share the concerns (without identifying the physician if you need more facts or if it is not necessary for the protection of patients) and get support from professional colleagues. This can be in a confidential conversation, a professional meeting, or as an inquiry to "Ask a Lawyer." Ms. Bowers' essay is a good example of a shared professional concern.

Another option is to talk with the questionable practitioner himself or herself. Tell that person what you have observed, and why it bothers you (AMA, the law, the dissatisfied patient who is more likely to sue if something goes wrong). Another approach is to make copies of relevant documents (e.g., parts of the Code of Ethics) available as a handout in your classes. A fourth approach is to share your observations and concerns with the risk management department in your local hospital. A fifth option is to file a complaint with the state medical licensing board.

The educator's choice of strategy will depend on personality and circumstances. Whatever the strategy, a professional will show dedication to providing competent care, dealing honestly with colleagues, and respecting the law.

Note: "Ask a Lawyer" answers are not official Lamaze International positions and are not intended to substitute for consulting with your own attorney. Nayna Philipsen welcomes your questions. Please send them to "Ask a Lawyer," Lamaze International, 2025 M Street NW, Suite 800, Washington, DC 20036-3309 or via E-mail to naynamom@aol.com.

Study Explores Effects of Formula Advertising on Breastfeeding Patterns

An article in the journal *Obstetrics & Gynecology* examines the effect that commercially produced materials about infant formula have on breast-feeding practices when distributed prenatally in an obstetric office setting. They found that exposure to formula promotion materials significantly increased breastfeeding cessation in the first two weeks. Also, among women with uncertain goals for breastfeeding or goals of 12 weeks or less, exclusive, full, and overall breastfeeding duration were shortened.

Howard, Cynthia, et al. (2000). Office prenatal formula advertising and its effect on breast-feeding patterns. *Obstetrics & Gynecology, 95*(2), 296–303.

A longer version of the above news brief appeared in the February 11, 2000, issue of MCH Alert, which is produced by the National Center for Education in Maternal and Child Health in Arlington, VA (http://www.ncemch.org/alert).