

**FIGO INTRODUCTION TO
PRINCIPLES AND PRACTICE OF
BIOETHICS:
CASE-STUDIES IN
WOMEN'S HEALTH**

By the Committee on Ethical Aspects of Human Reproduction and Women's Health,
International Federation of Gynaecologists and Obstetricians (FIGO)

2012



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PART I: BIOETHICS

1. Introduction - The Context

The purpose of this FIGO bioethics training programme is to equip medical students and practitioners of gynecology and obstetrics to understand ethical concerns that arise in women's health care, and to resolve these concerns by ethically as well as medically satisfactory means. Ethical sensitivity is based on awareness that, in many social and family settings, women have a different, often subordinate or disadvantaged, status from that held by men. This is associated with the different social and economic functions that women tend to perform, such as caring for newborn and young children, and disabled and elderly members of their families, rather than being engaged at the forefront of social, economic and political life.

Training in bioethics is required to bring out the best qualities of understanding of, and compassion for, their patients in gynecologists and obstetricians. Training is also required because ethical values increasingly underpin women's human rights entitlements that are expressed in laws. Access to appropriate health care is increasingly recognized to be a human right and legal right, of which medical professionals should be aware. Respect for these rights should be incorporated into clinical practice as an aspect of medical professional ethics and skill.

A challenge in bioethical analysis that should precede decision-making is for health care providers to understand the biases and stereotypes that they bring to the task of decision-making due to their own characteristics and cultural conditioning. Care and training are required to ensure that women patients are not viewed through assumptions and stereotypes that deny or compromise the human rights to which they are ethically entitled.

Human rights are detailed in legally binding or influential international treaties, national constitutions and/or national laws and codes, all reflecting contents of the Universal Declaration of Human Rights. This was proclaimed by the General Assembly of the United Nations in 1948. Rights include, for instance, rights to security of the person, to protection against suffering cruel, inhuman or degrading treatment, to found a family, and to non-discrimination on grounds such as sex, race colour, religion, national or social origin, and birth or other status. Such individual rights are expressions of the first sentence of the Universal Declaration, “All human beings are born free and equal in dignity and rights.” Respecting patients’ dignity, whatever their circumstances such as income, age, or origins, goes a long way towards satisfying ethical requirements.

A contrast is sometimes drawn between positive and negative rights. Holders of positive rights are entitled to be provided with means to give effect to such rights, for instance by governmental or other agencies. Most human rights are negative rights, meaning that holders must be free to give effect to their rights by whatever means they can lawfully mobilize. Those who deliberately obstruct others’ pursuit of their rights behave unethically, and often illegally. The human right to dignity, however, is both negative and positive. Individuals must be able to pursue this right by their own means, and must also be treated by others, including ethical health care providers, with respect for their dignity.

2. The Background of Bioethics

The term “bioethics” dates back only to the 1960s, but ethics, as a branch of moral philosophy, has ancient roots in many cultural traditions. Ethics may be understood simply as right conduct, and bioethics concerns correct conduct relating to human medical biology. Different reasons have been advanced to explain the origin and growth of bioethics. One concerns the development since the middle of the 20th century of advanced medical technologies affecting, for

instance, life-prolonging means that may be applied, or withheld, and means of bypassing infertility by medically-assisted human reproduction. Another concerns movements towards greater social equality, movements that resisted medical paternalism, in order to reduce physicians' superior power based on their medical knowledge, by promotion of patients' rights and power of self-determination, or autonomy. Yet another is decline in popular deference to authority, such as that formerly exercised by political, religious, professional, academic and related institutions.

There are various orientations to bioethical assessment. A contrast is often drawn between an approach that enforces abstract virtues and principles, and another that takes account of practical consequences. An approach that applies only principles ("Let right be done though the heavens may fall") may cause avoidable harm, while one that aims only at achieving desired results ("The end justifies the means") may be unprincipled and corrode, compromise or subvert key social and professional values. A more recent approach, of particular relevance to gynecology and obstetrics, is to ask how a policy, principle or option would affect women's well-being ("To ask the woman question"). Many traditional sources of moral or ethical authority, such as religious, legislative, judicial, academic and professional institutions, have not included women at all, or have not had women in positions of leadership. They have not been informed of, concerned with, or sensitive to women's experiences, preferences or opinions, and have not considered the implications or effects of their policies or actions on women. These authorities have been impoverished by not inviting or accommodating independent women's views, and by not knowing or respecting how women have to resolve competing responsibilities in their lives.

Modern bioethics is conscious of the need to respect individuals' values, including their religious beliefs, but approaches medical decision-making as a human function without guidance from any divine or supernatural agency. It is pluralistic in its incorporation of different philosophies, and encourages the

principled questioning of options for action rather than requiring unquestioning obedience to any given authority. Account is taken of the likely or possible consequences of available choices of action, weighing medical, psychological, familial, social, economic and other relevant considerations in balancing choices against each other. Individuals and institutions are held accountable for the intended and incidental consequences of their choices to act, and not to act.

Competing ethical considerations may be balanced in different ways, depending on different priorities. For instance, a physician deciding whether to offer or undertake a procedure liable to affect childbearing should take account of the woman's future childbearing intentions, hopes and prospects. Women anticipating childbearing and newly married women may be treated differently from post-menopausal women and those satisfied that their families are complete. In the same way that there may be different medical options, there may be different ethical options.

In order to take account of different ethical approaches to clinical care, research in reproductive health, allocation of scarce resources, and, for instance, balancing of competing interests, a small number of core principles have been identified in the field of bioethics. These are not applied in any hierarchy, but must each be assessed to determine which should be given priority over others to determine how selection of choice among treatment options is best made. There are often different ways of behaving ethically, and one's ethical choice in a given case does not show that another person's different choice is necessarily unethical. Bioethical principles can be applied in different priority, so that different choices can be equally justified. They all require, however, that practitioners give each principle due consideration, and be able to justify the priorities by which to decide.

3. **Ethics Principles**

The practice of medicine relies on the ability to put together medical findings and facts with evidence-based guidelines and research to craft a strategy for the unique circumstances that each patient faces. This “clinical” strategy often leads to questions about which approach is right, virtuous, or moral and more importantly how to achieve the same level of skill at practical wisdom and ethical choice in medicine as we have with clinical skills. At the heart of moral dilemmas in medicine are recurrent ethical principles that need to be examined, drawn from a considerable body of literature that guides the health care provider. While we could argue from a basis of practical consequences, a basis of proper motives and of discharge of duties, or of ideal personal virtues, the ethically relevant facts need analysis based on principles. These case studies focus on four major principles, namely to respect patients, promote benefit and to avoid or minimize harm, and to act justly.

Respect for Persons: Autonomy and Protection of the Vulnerable

This principle is often phrased around the duty to respect individuals’ right to choose which health care interventions are acceptable to them. It does not imply that there is a duty to offer health care interventions that are not medically sound or indicated just because a patient wants them. That is, autonomy is the right to choose among indicated and reasonably available options, not the right to receive any treatment the patient wants. Autonomy also includes the right to choose to have others involved in decision-making, such as family and community members.

Respect for persons is particularly important for women’s health (1), because in some cultures women are not respected as decision-makers. Respect for a person’s choices requires the person to have the capacity to make choices. This means that the person possesses (i) the ability to receive information of, and

to understand, the medical choices, and their benefits and harms (often described as informed consent); (ii) the ability to consider those benefits and harms in light of their own perceptions and values; and (iii) the ability to communicate their questions and their decisions meaningfully in the health care setting. Given the overall status of women worldwide, there are many circumstances that compromise the ethical foundation of autonomy, and therefore present ethical dilemmas. Women are often vulnerable to incapacities, such as when they are illiterate, and care must be taken both to maximize their means of exercising autonomous choice, and to protect them from harm, injustice and disrespectful treatment when they are disadvantaged and subject to others' choices.

Among the key ethical issues to consider in applying the principle of respect are:

- a. Whether the woman is free from coercion, pressure and undue inducement, applied consciously or incidentally by the health care provider, in her decision making. A power differential between the health professional and patient or accompanying persons or family member may make it difficult to understand the individual's choices. Is it really her wish or that of others, such as her children, her husband, or someone else, for instance her village elder? (2)
- b. What is the capacity to make choices, and who decides when the person appears to have diminished capacity? Waxing and waning consciousness, or a child's or adolescent's level of capacity to choose, raises issues about who can be a substitute decision-maker, and whether or not that person will recommend a course that would be true to what the individual might want, rather than express the decision-maker's own beliefs or wishes.
- c. What are the obligations of health professionals to be sure the patient "understands", given the gap between the knowledge base of the clinician and of the patient? Is it truly possible to give adequately informed consent knowing that the variables are so many in clinical medicine, and that not all outcomes can be

foreseen? How do we assure that comprehension of language (for instance through interpreters and scaling information to the knowledge level of the patient) and adequate understanding of the consequences of the choice for benefit and harm are present?

d. Finally, confidentiality in decision-making is a key area for protecting a patient's right to make a choice, but the limit of that duty may be unclear (for example, if a patient's choice will deny the power of self-protection to another person by not revealing his or her HIV-positive status to a spouse or partner). In principle, patients should determine who receives medical information about them, as an aspect of their autonomy.

Benefit and Avoidance of Harm: (Beneficence and Nonmaleficence)

As Hippocrates directed, "Be of benefit and do no harm." This represents the clinician's duty to improve the patient's physical and psychological health with a favourable benefit-to-risk ratio. This requires considering prospective advantages of a treatment option, weighing the side effects or consequences that could cause harm, and assessing the advantages for the patient adequately to exceed the disadvantages. The practitioner must ask what clinical needs are present, and how the choice of actions will address them to the benefit (good) of the patient.

Leading commentators on clinical ethics have noted (3) that "good" must be understood in light of achieving a goal of medicine, not for instance merely normalizing laboratory values or stopping a bleeding point. This requires answers to the questions: Does the proposed action cure or stabilize disease? Does it stop untimely death or promote health and prevent disease? Does it provide good quality of life or relief of suffering? Making sure that the goal of treatment is clear allows clinicians to make sure that the benefits and harms of treatment options are properly assessed in judging the ethical issues at hand, and in

particular to assure that policies that impact the direct care of women's health are based on best available evidence.

Justice

Justice addresses what entitlements are due to individuals for their health care. The right of individuals to fair and equitable distribution of the benefits and the risks or burdens of available health care (that is, distributive justice) is particularly relevant regarding women's sexual and reproductive rights (4).

The scope of potential ethical issues involving justice extends far beyond the immediate concerns raised by the one patient in front of us. Justice demands that we consider the formulation of health care systems and the extent to which they provide fair access and benefits, particularly for women, who are often shut out of access due to economic, social, or political disadvantages and exclusion. (5) Justice raises questions about how we distribute scarce resources (such as the HPV vaccine), whether, for example, on a first come-first served basis, by lottery, based on the greatest health, social or other need among competing patients, on the greater means to pay, or on some other formulation.

Justice asks if the decision-maker might be compromised by a conflict of interest, or for instance by cultural, religious or other beliefs that do not allow lawful medical means of best serving the woman's needs. Other concerns include whether we feel bound by duties that may conflict with duties to patients alone, for example for family safety, staff safety, triage that applies scarce resources only to those who are likely to survive, even if those denied resources will suffer. These kinds of tradeoffs and considerations face health professionals in every form of medicine on a daily basis. Skill at justly weighing such competing interests against others in determining appropriate treatment options in the care of individual patients may be the hardest skill to achieve in medical ethics.

1. FIGO Ethics Committee. Ethical Framework for Gynecologic and Obstetric Care. www.figo.org 2009
2. FIGO Ethics Committee. Guidelines Regarding Informed Consent. www.figo.org 2009
3. Jonsen AR, Siegler M, Winslade SJ. Clinical Ethics. 7th edition, 2010. McGraw Hill Medical. New York.
4. FIGO Ethics Committee. The Ethical Aspects of Sexual and Reproductive Rights. www.figo.org 2009

4. **Levels of Analysis**

Bioethical assessments can be made at four levels, but the principal level concerns the doctor-patient relationships. This is the microethical or person-to-person level. For development of skill in ethical decision-making in clinical care, this is where major attention and training are required. Most of the case-studies in this training programme are pitched at the doctor-patient relationship.

In contrast, the public health, macroethical level is concerned with group-to-individual and group-to-group relationships. In between is the administrative, bureaucratic or mesoethical level, which addresses resource allocation within an institution such as a clinic or hospital, or in a governmental structure such as a village, town, city, local region, or nation. Transcending these levels is the megaethical level, sometimes described as global ethics, addressing international and intergovernmental relations and agencies in the health care sector.

Decisions that are ethically defensible at one level may be ethically challenged at another, so practitioners may have to start their analysis by determining its appropriate level. For example, a provider may order an additional test on a generally healthy patient, such as an X-ray, or CT (cat) scan, out of an abundance of caution in the patient's interest. This may be microethically defensible. However, at the mesoethical and macroethical levels, when supply of the test draws on a group's limited resources of funds, personnel, and/or access to

equipment, it may be criticized as an extravagant use or waste of scarce resources, denying indicated treatment of a sick patient. Similarly, a survey of long-term treatment-effects on cervical cancer patients may require review of patients' identifiable medical data. This may be ethically defensible at a macroethical or public health level, but compromise patients' confidentiality at a microethical level.

Ethical challenges arise when a provider is responsible for care of two or more patients whose treatment requires use, for example, of a drug of which the facility has a supply sufficient for only one, or of equipment, the use of which for one will deny its timely availability to the other(s). The provider must resolve this conflict of commitment by evaluating one patient's ethical claims over those of the other patient(s). The provider may explore, for instance, whether differences in the patients' medical status affords an ethically relevant distinction that justifies favouring one patient over the other(s). For instance, a decision simply favouring the younger over the older, or vice-versa, or, a mother with dependent children over a childless patient or one with adult children, will have to overcome ethical and related human rights claims to non-discrimination on grounds of age, marital status or number of dependents. The choice is more complex when a patient with no dependent children is caregiver, for instance, to a disabled or elderly relative.

Practitioners with clinical care responsibilities may also be required to serve in administrative positions that involve, for instance, allocation of resources. They may then have to make mesoethical choices that conflict with their microethical duties to provide their own patients with the best possible care, such as, on grounds of institutional budgetary discipline, to terminate or restrict availability of expensive drugs or devices their own patients need for adequate care. Ideally, such conflicts should be avoided by administrators not having clinical responsibilities, but may be unavoidable due to personnel shortages and during transitional periods between clinicians' appointments to managerial roles.

Apparent inconsistencies or contradictions in preferences or policies may be resolved by reference to different levels of analysis. For instance, some who support women's choice to continue or terminate pregnancies without legal control also support laws prohibiting prenatal disclosure of fetal sex. Their purpose is to restrict opportunities for sex-based abortion, perceived to target female fetuses. Those who favour both policies may explain that the abortion decision should in principle be made at the microethical level, between a woman and her doctor (see FIGO Ethics Committee; *Ethical Aspects of Induced Abortion for Non-Medical Reasons*, 1998). The decision to prohibit prenatal disclosure of fetal sex, however, is in principle a macroethical decision to be reached at the societal or public level (see FIGO Ethics Committee: *Sex Selection for Non-Medical Purposes*, 2005). This is because it may affect women's social status, dignity, and equality with men in their communities. Sex-selection, other than for sex-linked genetic disorders or, although controversially, to produce a family with children of both sexes, may also cause social disorder if it causes or aggravates a serious imbalance in a national sex ratio, for instance resulting in a large number of adult men who are unable to find wives. In addition, rejection of sex-selection may be of megaethical significance in reinforcing the equal status of women in all cultures and communities, reflecting condemnation of discrimination against girl children and women in international human rights treaties.

5. Clinical Case Analysis

Having a format in which a clinical case can be analyzed for ethical assessment and decision-making is much like separating a clinical presentation, for purposes of informing patients' decision-making on medical matters, into symptoms, observations, assessments and plans. Routine use of one of the case structures for analysis leads to facility in thinking through the ethical dilemmas often encountered in reproductive health in general and women's health in particular. It is important to progress from just discussing hypothetical cases to using cases encountered daily in practice to hone ethics skills, and then to use the hypothetical

cases to add background and the comfort of knowing that others have pondered similar cases in the past.

Common to all methods is the need to be sure that the information gathered is accurate, and both medically and patient-based. Additionally, the ethical decision-makers involved (including the entire health care team) and the possible options and issues need to be brought to the table, including the legal framework where necessary. Finally, an analysis with justification from ethical and social perspectives can be shared before the final options are decided on. In developing ethics consultation services, an additional option of including the patient and her family, when feasible, has been applied successfully in many settings, and may enhance the environment of patient-/woman-centered care in institutions.

Routine use of the 4-box method proposed by Jonsen, Siegler, and Winslade is suggested for ease of application from the clinician's point of view. This method is philosophically a casuist (that is, a case-based) approach that assumes there is a clear paradigm case (perhaps more like one of the sample case-studies following), and then develops different variations that require discussion and collective analysis. Practically, an easy way is to form 4 boxes and fill in each sequentially and completely (along with the ethical issues raised in the box) before overall discussion of the case occurs. Often, the "clear" case, for instance of benefit and harm, turns out to be a different case, such as of autonomy or protection against vulnerability, or another principle rather than the one that seemed so clear on initial focus on just one area. A unique set of ethical dilemmas in reproductive and women's health is one in which there is a fetal as well as a maternal issue for consideration, and division of the boxes to represent the issues for both mother and her fetus or child can facilitate thinking.

The 4 boxes are conceived as: 1- Medical Indications (including the principles of benefit and harm); 2-Patient Preferences (autonomy or protection, capacity to choose); 3-Quality of Life (how does the woman see the intended results of a

prospective intervention from her life circumstances, and the impact on her quality of life); 4-Context (Justice issues). While these are well described in Jonsen, Siegler, and Winslade, the diagram provided below takes into consideration unique aspects of reproductive and women's health (A) and/or fetal/child health (B) that may apply in the individual box. (Table 1)

Table 1: 4 boxes for Reproductive/ Women's Health

| | |
|---|---|
| <p>1A Medical Indications: Describe the medical circumstances, benefits and risks of proposed interventions and goals of medicine achieved by intervention. (Examples: HPV vaccine benefit versus risk; C section for obstructed labour; female genital cutting; pain relief for advanced cervical cancer)</p> <hr/> <p>1 B Fetal considerations (for example, death without intervention, significant morbidity with HIV or prematurity)</p> | <p>2A Patient Preferences: Describe what the patient wants (not what her health professionals or her family or her spouse wish, but only what the patient wants), her understanding of the issues, the potential issues of coercion, language, power differential and how they influence authenticity of decision making, issues concerning capacity to choose, and protection of those incapable of choice.</p> <hr/> <p>2B Consider fetal/ child potential wishes as a substitute decision maker: for example, what data exists to understand choices about severe disability, or survival without a mother if that is the consequence. This may be unknowable.</p> |
| <p>3 Quality of Life (as defined by the patient, not by the health care team). This requires exploration with a patient about what the proposed intervention options will mean to her. (Example: the loss of a child may have great or little meaning for ongoing quality of life; participating in a research study with significant side effects may be chosen because quality of life is defined by the woman by whether or not she is contributing to knowledge for the next woman with her cancer; or side effects may be intolerable because of an impact on her ability to pursue an occupational or leisure activity, such as to knit, weave, read, sing or play a musical instrument, which defines her quality of life)</p> | <p>4A Justice: Describe issues of distributive justice, economic issues (access, cost), health professionals' concern (their view of quality of life achieved by the therapy), just society issues (treatment of women within the culture), role of religion or other influences on choices</p> <hr/> <p>4B Fetal/Child issues: Cost of care of prematurity and consequent neurologic needs, lack of maternal or parental support growing up (if maternal death, HIV-positive status, etc.), paternal or health team issues</p> |

PART II: CASE-STUDIES

Introduction

In order to provide students and others with experience of ethical decision-making in gynecology and obstetrics, case-studies are presented below for analysis. They are based on real-life situations, but facts are usually given in a simple form, so that readers have to address their ethical elements, and not attempt to evade ethical engagement by resort to medical or technical means, or development of additional facts proposed to resolve situations without ethical reflection.

Facts of the cases are followed by some questions, but readers should consider what additional questions are ethically relevant. Background factors are presented in the Assessment sections to place the cases in some of their wider settings, but readers should identify factors from their own circumstances and experiences that they consider ethically relevant. Ethical Analysis sections are then introduced, but not to indicate ethical outcomes or approaches. The purpose is to initiate reflection and criticism in the context of ethical principles, and begin to address applications of relevant principles, perhaps showing contrasts and conflicts that applications may generate. Readers have to work out responses and actions they would propose in each of the cases as being ethically justified and appropriate.

Discussion of ethical elements in cases often shows that there are different ways of acting to resolve them ethically, depending on what factors in cases are claimed to warrant emphasis, what ethical principles are considered to merit priority over others, and the level of analysis of cases seen to be appropriate. Ethically reasoned conclusions that colleagues offer may show that there are different ways to act ethically. That is, differences between reasoned conclusions may not show that, because one is ethical, another that differs is therefore necessarily unethical, but that different types of ethical analysis can result in different ethically justified conclusions. In ethics, unlike, for instance, in some forms of religion, there are no authoritative rulings that command obedience. Individuals must find ethical solutions by themselves, in consultation with others if they wish, and justify them by the processes of ethical reasoning they find most appropriate and most defensible.

Following the Ethical Analysis sections that open consideration of the cases are a few References. These are primarily to FIGO Ethics Committee statements and recommendations, which are collected in the FIGO publication entitled " Ethical Issues in Obstetrics and Gynecology by the FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health" (i.e. the Ethics Committee). This FIGO publication is available in English, French and Spanish, and is accessible online at <http://www.figo.org/about/guidelines> . The print edition is updated every three-years for the FIGO Congresses. The next edition will be dated 2012.

To supplement these references, students with access to adequate libraries and/or Internet resources will find many relevant articles and commentaries in medical and bioethical journals and other reference materials. These may include, for instance, the British Medical Journal, The Lancet, The New England Journal of Medicine, and similar national and international medical professional journals. Internet access to many journals is free of charge, and other materials may be accessible by university, medical school or other subscriptions of which registered students may avail themselves. As with all such materials, students should be critical of their origins, their liability to (undisclosed) biases, and the contrast between goals of disinterested bioethical analysis, and of ethical advocacy advancing particular interests or perspectives.

Adolescent Sex and Confidentiality

Case:

Mila, a 15 year old girl studying in secondary school, has come to Dr Chidi's office requesting confidential access to contraceptive care. She explains that her poor family cannot afford school fees. For several months, a 50 year old 'sugar daddy' has paid her tuition fees, provided she agreed to have non-protected sex with him twice a week and does not tell any family member or friend. She is upset and restless day and night, and afraid of becoming pregnant.

Questions:

Can Dr.Chidi ethically provide Mila with contraceptive care, by prescription or otherwise?

Is Dr.Chidi ethically obliged to respect Mila's request for confidentiality?

Does Dr.Chidi have any ethical duty or discretion to report Mila's association with the man to her parents, police authorities, or a child protection agency?

What advice, if any, should Dr Chidi ethically give Mila apart from regarding contraception?

Assessment:

Laws in many if not all countries prohibit sexual intercourse ("sex") with adolescents below a given age, such as 16. Some make an exception if the sexual partner is less than, for instance, three years older than the adolescent. Laws that criminalise older partners, such as the 50 year old man in this case, do not also criminalise the adolescent, or make her a delinquent. Accordingly, Dr.Chidi would not be facilitating any offence Mila commits by providing her with contraceptive protection.

The human rights of adolescents are declared in the International Convention on the Rights of the Child. This generally applies to every human being under the age of 18, and has been ratified by every country in the world (except Somalia and the USA). The Convention recognises the rights and responsibilities of parents, to be exercised consistently with "the evolving capacities of the child". In some laws, this is described as the "mature minor" doctrine. This affords adult capacity for certain purposes, particularly receipt of reproductive health services, to legal minors who are sufficiently mature to bear responsibility for their own decisions. Maturity is not age-specific, and has to be determined on a case-by-case basis, specific to a particular adolescent, and a particular decision. When adolescents are mature, meaning that their capacities have sufficiently evolved to be responsible for their decisions, they have the same entitlements as adults, who may at times make poor or imprudent choices. Courts have ruled that minors sufficiently mature to consent to medical treatment by themselves may also decide who may gain information about it. That is, their right to decide on medical treatment includes the right to confidentiality.

This means that if Mila is considered mature, she may consent to sex without it being rape. Consensual sex with an adolescent below a legislated age is sometime described as “statutory rape”, to distinguish it from non-consensual sex.

Ethical Analysis:

Respect for Persons:

Mila is engaging in what is sometimes described as transactional sex, meaning the exchange of material goods or other benefits in return for sex. In some circumstances, especially of deprivation, this has become the norm for adolescent girls, being their main source of income, and paying for their education.

It is evident that Mila would prefer not to have regular sex with the 50 year old man, but resolved the unfortunate choice between preserving either her sexual integrity or her education in favour of the latter. If Mila is considered mature, she may appear to have made an autonomous decision of what she considered the less bad option, and her choice will warrant respect as well as sympathy. Dr.Chidi may find evidence of Mila’s maturity in her request for contraceptive protection, and in her discomfort and perhaps suppressed anger that her family’s poverty, and her resulting vulnerability, are being exploited. Dr.Chidi may accordingly provide contraception.

The ethical principle of respect includes protection of vulnerable persons, and while Mila may have made a mature though reluctant choice to agree to transactional sex, she may appear vulnerable. Dr. Chidi cannot protect Mila against her family and social situation, but may provide additional advice, such as against sexually transmitted infections, including HIV, how she may negotiate with the man for safer sex, and how to manage her distress and restlessness.

Benefit and Avoidance of Harm:

Since Mila is at risk of unwanted pregnancy, providing an appropriate means of contraception would appear beneficial to her. For benefit to be maximised, however, additional medical assistance and counselling may also be indicated, as addressed above concerning vulnerability.

Because of the extended meaning that may be afforded the concept of violence against women, this case of sexual exploitation of Mila’s family poverty, and of the power imbalance between a 15 year old schoolgirl and a 50 year old man of financial means may also be helpfully understood as a form of violence. Violence may be seen as a risk factor for the ill-health, physical and/or mental, of women of any age. However, violence against women, of any age and in any form, is to be terminated on discovery whenever possible. A harm to Mila of intervention in this case may be discontinuation of her education, and of all the prospective benefits that education may bring, including her release from poverty.

Justice:

A key concept of the ethical principle of justice is that, among autonomous individuals, and to the fullest extent possible involving persons of impaired autonomy, those most affected by decisions should be most influential in making them. Accordingly, Mila should decide who knows about her relationship with the 50 year old man. If she is a

mature minor, she is entitled not only to appropriate medical care, but also to medical confidentiality. Mila may accordingly decide whether her parents, school health authority or others can have information of her care. This may require Dr. Chidi not to be explicit in billing for medical services rendered, in case her parents, school or others have legitimate access to her medical records. If contraception is given by prescription, Dr. Chidi may have to advise Mila how to have it filled with maximum confidentiality.

If Mila is considered not to be mature, she should be afforded due protection, such as by Dr. Chidi reporting the circumstances to persons or agencies able to afford Mila protection. Account must be taken, however, of the effect on Mila's education, and of other means she may employ to earn payment of fees in order to remain at school. Further, while the sexual relationship exists, she will require contraceptive and associated protection.

Beyond Dr. Chidi's clinical responsibilities are ethical responsibilities at the level of social justice. Access to free education for all children and school-age adolescents correlates highly with indicators of good health. The promotion of a right to accessible education for children and adolescents of all family income levels is an integral part of health care at the macroethical level of ethical analysis. Dr. Chidi has ethical responsibilities, as an individual and through participation in a professional society, to advocate for a school system to which adolescents will have access without resort to the means MG found she had to employ.

References:

FIGO. Statement on Adolescent and Youth Reproductive Health Care and Confidentiality.

UNESCO Chair in Bioethics Reproductive Health Case Studies with Ethical Commentary B M Dickens, R J Cook, and E Kismodi

Reproductive Health and Human Rights R J Cook, B M Dickens and M F Fathalla
Oxford University Press, 2006

Adolescents and Family Planning

Case:

Patricia, aged 15, is in a sexual relationship with Pablo, aged 19. They intend to marry each other when Patricia is aged 18. They go to their local hospital gynecology department and ask Dr. Aye for a family planning method. Patricia is liable to epilepsy and has been taking Phenytoin for the last seven years, making her ineligible to take a low dose oral contraceptive or a combined injectable contraceptive method. Dr. Aye advises Patricia to consider use of a copper intrauterine device (IUD) and advises the couple on condom use to prevent sexually transmitted infections (STIs).

Local law prohibits any sexual intercourse by those aged under 14 years, and under 16 years except with partners less than three years older.

Questions:

Can Dr. Aye ethically advise this couple on contraceptive means they can use?

Can Dr. Aye ethically fit Patricia with an IUD?

Does Dr. Aye have an ethical duty to advise Patricia's parents of any proposed contraception?

Can Dr. Aye ethically bill Patricia's parents for services?

Assessment:

Because of Patricia's treatment to control epilepsy, common means of self-administered contraception are contraindicated for her. Insertion of an IUD requires the attention of a gynecologist, and her education on its maintenance. Protection against STIs is important, since two-thirds of all STIs occur among persons under 25 years of age, and one quarter among teenagers.

Laws against sexual intercourse with minors and adolescents are intended for their protection. Accordingly, while their older sexual partners may commit offences, they do not, since they are regarded as victims rather than as perpetrators of, or conspirators in, such offences.

Ethical Analysis:

Respect for Persons:

If Dr. Aye finds responding to these requests for assistance objectionable, Patricia and Pablo should be referred to another physician who will care for them. Dr. Aye's protection of Patricia against unwanted pregnancy by medically appropriate means serves her interests in autonomy. However, Pablo is not legally free to engage in sexual intercourse with her, on account of his age and her perceived vulnerability. He is entitled to receive advice on means to prevent causing unwanted pregnancy, and on means to avoid contracting and transmitting STIs.

If Patricia is mature in her capacity for medical decision-making, she is entitled, as a mature minor, not only to accept medical care for her protection but also to decide with whom that information may be shared. Dr. Aye may accordingly respect her decision on whether her parents are brought into or advised of her medical treatment

decisions. If Pablo's intercourse with Patricia is unlawful, it cannot be remedied by her parents' consent. If she is a mature minor, Patricia can decide whether she requires her parents' protection against any legal offence Pablo may commit.

Benefit and Avoidance of Harm:

Protection of Patricia against unwanted pregnancy and STIs is of benefit to her. Advising Pablo of his liability to commit a legal offence by having intercourse with her before she reaches 16 years of age is beneficial to him, and to Patricia, if she wants to safeguard him against committing any (further) offences. Dr. Aye cannot provide Pablo with advice on having safe intercourse with Patricia, since this may appear to be aiding and abetting an offence, but may provide him with non-specific advice on contraception and STI protection of, and from, any sexual partner.

Justice:

How Dr. Aye is remunerated for services to Patricia and Pablo may raise ethical concerns of justice. If services are billed to Patricia's parents or health insurer, information may be required of the service rendered. To preserve confidentiality, however, this may have to be generalized, such as for gynecological care, not specific to contraception. Further, any such billing cannot cover consultation with Pablo. If care for both Patricia and Pablo is covered by public funds, it must be for separate services to each, since public funds cannot ethically be applied for safety in a joint act or acts in breach of the law. Law is often described as providing a "minimum ethic," because ethical conduct often requires more than simple conformity to the law. That is, ethics may require that individuals do more than just meet their legal responsibilities. However, this also means that it is usually unethical to act, or to facilitate action, in breach of the law.

References:

FIGO statement. Adolescent and Youth Reproductive Health Care and Confidentiality, 2

FIGO statement. Ethical Aspects of the Introduction of Contraceptive Methods for Women.

FIGO statement. Ethics in Family Planning.

Anencephaly and Late-Term Abortion

Case:

Ana is the 33 year-old mother of children aged 11, 8 and 6. She lives in a low-income family with her 37 year-old husband and works occasionally in a car wash, while her husband has part-time employment as a driver. The IUD Ana used for contraception was spontaneously expelled, and now she is 23 weeks pregnant. An ultrasound examination at the government-funded community clinic has diagnosed an anencephalic fetus. Local law allows induced abortion on grounds of a woman's physical or mental health, limited to 20 weeks' gestation except in exceptional circumstances. Dr. Gomez, attending Ana at the clinic, told Ana about the risk of stillbirth of an anencephalic fetus, and the strong likelihood of a baby's early death on live birth. Ana was also informed that the clinic and Dr. Gomez disfavour abortion, and that, because anencephaly is not of genetic origin, organs from her child following death might be recovered for transplantation to assist sick children's survival. Ana and her husband ask for immediate termination of the pregnancy.

Questions:

Are there ethical grounds for Dr. Gomez to terminate the pregnancy?

Is the possibility of organ recovery for transplantation at the baby's death a ground to refuse abortion?

What are the ethical responsibilities of Dr. Gomez if refusing abortion on grounds of conscientious objection?

What are Dr. Gomez's ethical responsibilities if the clinic is not equipped to undertake a late-term (post-20 weeks' gestation) abortion?

Are the interests of Ana's young children of any ethical significance in responding to her request?

Assessment:

The incidence of anencephaly is uncertain in countries with prenatal diagnosis and accommodating abortion laws, because diagnosed cases often result in abortion. The condition is assessed to occur in about 1 per 1,000 live births in the USA, and 6 to 8 per 1,000 for instance in parts of the UK. The incidence among live births is higher where abortion is legally restricted, such as in Latin America. Anencephaly is the most severe fetal neural tube defect, resulting from failure of the neural tube to close at the base of the skull in the third or fourth week after conception. The brain therefore lacks part or all of the cerebrum, and brain tissue is often exposed to injury from amniotic fluid. Stillbirth is the outcome in about 65% of cases, and children born alive are non-viable, usually dying within a few days if not hours. The etiology of anencephaly is unknown, but data suggest origins in poor diet, especially folic acid deficiency. Anencephaly is associated with risks of dysfunctional labour and complicated delivery, and stressful newborn care until death.

Ethical Analysis:

Respect for Persons:

Ana's autonomy may entitle her to abortion, if she is considered an exceptional case allowed by the law. The general limit of abortion at 20 weeks' gestation balances health risks to women against fetal interests in survival, but anencephalic fetuses, even if born alive, are not viable. Dr. Gomez has autonomy to decline to participate in abortion, but then has to consider referral to a non-objecting suitable practitioner. Referral is not participation, and does not attract the protection of conscientious objection. The clinic administrators similarly cannot invoke conscientious objection, since administration is not direct participation in procedures administered. However, the clinic's inability to undertake a late-term abortion raises the issue of whether transfer to an adequately equipped clinic is ethically required.

Benefit and Avoidance of Harm:

The fetus would not be harmed by abortion, since, lacking a functioning cerebrum, it is incapable of consciousness and experience of pain. Its brain stem may support reflex action such as breathing and occasionally responses to sound or touch, but it is not viable or treatable. Dr. Gomez might be harmed if compelled to perform an abortion, contrary to the doctor's conscientious convictions. Sparing Ana the experience of delivering a stillborn or dying baby would be beneficial, but there might also be benefit to any sick child that might survive if transplanted with an organ from Ana's deceased baby. It is uncertain, however, whether determination of the baby's death would be in sufficient time for removed organs to be suitable for transplantation.

Justice:

Ana and Dr. Gomez are equally entitled to protection of their dignity. In its 2005 decision in the case of *KL v. Peru*, the UN Human Rights Committee found that the state had committed multiple violations of the International Covenant on Civil and Political Rights when state agents obstructed lawful abortion requested by a young woman pregnant with an anencephalic fetus. Compelling her to deliver and breast feed the newborn dying baby unjustly caused her to suffer deep depression, and was found to constitute cruel, inhuman and degrading treatment. Compelling Dr. Gomez to perform abortion in violation of conscience may similarly be degrading to the doctor. Encouraging Ana to continue gestation to its natural end may spare her the intrusiveness of late term abortion, and provide her with an opportunity for altruism through organ donation, whether or not any child could receive organs transplanted from the anencephalic baby following its death.

References:

FIGO statement on Ethical Aspects in the Management of the Severely Malformed Fetus,

FIGO statement on Anencephaly and Organ Transplantation.

Figo Ethical Guidelines on Conscientious Objection.

R.J.Cook J.N. Erdman , M.Havia, B.M.Dickens .Prenatal Management of Anencephaly,
International J. Gynecol Obstet, 2008; 102(3): 304-8.

Antenatal Care

Case:

Francesca is pregnant for the third time. She has two healthy young children, a boy and a girl, after normal pregnancies. She is now 41 years old, married, and works as a hospital nurse. During this third pregnancy, she experienced slight genital bleeding at ten weeks, but had no further bleeding. She feared a miscarriage, but her physician was reassuring, since the clinical examination was normal, the uterine cervix was closed. However, at 20 weeks, a routine ultrasound examination identified several fetal anomalies: a severe cardiac malformation, bilateral club foot, and short nasal bones. Her physician told Francesca that these malformations were usually indicative of a risk of Down's syndrome, trisomy 21, a chromosomal abnormality due to an extra chromosome 21. Francesca knows by professional experience that fetal trisomy can be identified from a sample of fluid from amniocentesis, after culture of the fetal cells in the amniotic fluid. However her physician denies Francesca access to amniocentesis, because the country's law prohibits termination of pregnancy based on fetal malformation. The physician explains that prenatal diagnosis of fetal anomaly would be of no benefit to her, and that investigations will be performed only after birth of the baby. The physician adds that cardiac malformation is probably not curable by surgery. Francesca knows that Down's syndrome entails hazards of mental retardation and, in addition to the heart disease, a variety of possible somatic illnesses such as leukaemia. Francesca, deeply concerned by the severity of the cardiac malformation and its poor prognosis, and the foreseeable ordeal to the future child's life and to her family, insists that her physician should provide termination of the pregnancy.

Questions:

Can the physician ethically comply with Francesca's request?

Can the physician ethically terminate the pregnancy on grounds of harm to Francesca's physical or mental health, if the law allows these grounds?

Can the physician ethically take into account harm to Francesca's young children from birth of a severely handicapped newborn?

Is it ethical to deny antenatal diagnosis when a fetus is liable to be severely malformed and incurable before or after birth?

Assessment:

The risk of Down's syndrome increases with maternal age above 35 years. After 41 years, it is estimated to affect 1%-2% of fetuses. Screening for Down's syndrome is optimally performed, for all pregnant women who consent, during the first trimester of pregnancy, between 11 weeks and 14 weeks. A second trimester ultrasound examination may identify fetal malformations, including cardiac malformation and duodenal atresia, which suggest Down's syndrome. It is then recommended to conduct amniocentesis, and, on proof of Down's syndrome, to discuss termination of pregnancy with the pregnant woman.

Legislation for medical termination of pregnancy varies among countries. In some, it is allowed for a severe fetal disease or malformation until the end of pregnancy.

In others, termination is allowed only until 28, 24 or fewer weeks. In some countries where termination is generally forbidden, it is allowed when the woman's life or health is at serious risk.

In all countries, it is prohibited actively to induce death of a neonate (neonatal euthanasia), even for a severely malformed baby. Further, neither antenatal diagnosis nor termination of pregnancy may be imposed on a woman who does not give her free and informed consent.

Ethical Analysis:

Respect for the Person:

In principle, personal autonomy requires that a woman should be free to decide whether she is willing or not to give birth to a severely malformed, heavily handicapped, incurable child. If she wishes, she may decide in consultation with her partner and/or family members. She may opt for termination of pregnancy for two related reasons: she does not want her child to suffer the ordeal of unbearable life, and she does not herself feel emotionally strong enough to cope with her child's handicap, and perhaps its effects on her family. In many countries, however, women's autonomy is denied by laws of different levels of restriction.

Benefit and Avoidance of Harm:

The principle of benefit to the born child requires balancing the benefit of birth against the harm of a future life that may be inordinately painful and distressing. However, less impaired children who survive with Down's syndrome can enjoy years of comfort, and be a source of pleasure and companionship to others.

Justice:

Where medical termination of pregnancy is illegal, the physician has an ethical obligation to obey the law. The physician also has an ethical obligation to counsel and support patients and their families. Some physicians stretch the boundaries of laws that prohibit medical termination of pregnancy, privileging their ethical duty over their strict legal obligation. Others may advise patients that treatment unlawful at home may be accessible within the law abroad. The duty is to obey the law, not necessarily to respect it. Physicians have the ethical right, and perhaps duty, to urge reform of oppressive laws that cause harm to patients' health, particularly that of vulnerable women.

References:

FIGO statement on Ethical Aspects in the Management of the Severely Malformed Fetus,

FIGO statement on Ethical Issues Concerning Prenatal Diagnosis of Disease in the Conceptus.

FIGO statement on The Role of the Ob/Gyn as an Advocate for Women's Health,

Bioethics and Faith-Based Organizations

Case:

Doctors who work in the Department of Obstetrics and Gynecology at City Hospital, chaired by Dr. Civis, have been informed that they will receive necessary government subsidies for patients' care and research support only if they create a committee to review their practices and research proposals according to modern standards of bioethics. City Hospital serves an urban population of mixed races and religions, with a relatively high rate of maternal mortality and morbidity, and of infertility, and is organized and maintained by a religious foundation. The Hospital Chief Executive Officer asks Dr. Civis to ensure that a majority of committee members will be strictly observant followers of the religion to which the Hospital foundation adheres, in order to comply with the foundation's religious values.

Questions:

Can Dr. Civis comply with this request?

Can Dr. Civis comply if the religion excludes women from holding influential rank in the religion's authoritative hierarchy?

Must Dr. Civis ensure the committee's independence?

Assessment:

Health care facilities founded by religious institutions are entitled to maximize observance within them of the religious values the institutions uphold and promote. Bioethics is a pluralistic discipline, however, and secular in that it does not incorporate any supranatural belief system. It applies evidence-based rather than faith-based practices and policies, and its values are related to human rights rather than to religious convictions. Its methodology is based on analytical questioning of claims of correct conduct rather than on obedience to hierarchical authority.

The important bioethical principle of respecting persons requires that individuals be treated with sensitivity to their religious faiths, and that they not be required to act, or to suffer acts of others, that offend their religious convictions. The Constitutional Court of Colombia has held, however, that institutions such as hospitals cannot invoke conscientious objection to lawful medical procedures on their own behalf, because the human rights to freedom of conscience and of religion are available only to human beings, not legal corporations.

Ethical Analysis:

Respect for Persons: The autonomy of persons capable to make their own decisions requires that their own religious preferences be respected, and that they not be compelled to be governed by religious values they do not share. Accordingly, they should be facilitated to obtain lawful health care procedures appropriate for them, despite adherents to some religions finding the procedures unacceptable, and to decline procedures to which they object, despite others finding them acceptable. Further, physicians should inform their patients about lawful procedures medically indicated for their circumstances,

even if the physicians decline to undertake them on grounds of conscience, and be referred by their physicians or by others on their behalf to reasonably accessible providers able and willing to undertake such procedures.

Because of their dependency, patients seeking care are vulnerable to subjugation of their own preferences by those who possess the power of relevant medical or other knowledge. It is an unethical abuse of such power if patients are compelled to receive care that offends their religious values, or if they are denied information and/or care relevant to their circumstances because the care offends the values of the health care institutions or personnel that profess to serve them.

Benefit and Avoidance of Harm:

It is beneficial that institutions be able to function consistently with the religious or other values that inspire them, but harmful if they induce pluralistic populations to rely on them for health care or other services but deny lawful health services that they object to deliver because of their religious beliefs. It is also deceptive if, under the guise of functioning according to bioethical standards, they practice according only to religious beliefs. If the population that City Hospital serves has alternative access to other hospitals, physicians in the Department of Obstetrics and Gynecology may refer patients to them for services that it would offend the hospital foundation's religious values to deliver. If patients have reasonable access, including affordable access, to alternative facilities, Dr. Civis may therefore ethically comply with the request regarding the bioethics committee's composition, by publicizing where patients may obtain services the hospital will not deliver. Otherwise, a choice must be made between acceptance of governmental support and delivery of services according to the pluralistic standards of bioethics, or maintaining religious values but forgoing governmental subsidy and support, and tolerating the harm of failing to relieve high rates of maternal death and morbidity, and of infertility.

Justice:

Reproductive health in general and obstetrics and gynecology in particular centrally focus on women's health. Ethical rules distinguishing proper from improper practices in these areas should be informed by their impact on women, and by women's perceptions and experiences. It is questionable whether rules principally affecting women's health developed by institutions that do not include women in their senior ranks of influence can be ethically authoritative. Many religions have unchanged histories of women's subordination, exclusion and passivity, which their women followers find it too challenging to mitigate.

Justice requires that members of ethics review committees act independently of other authorities, assessing the relevance and priority of bioethical principles free from others' direction, although open to persuasion by others whose explanations they find ethically compelling. They have an unacceptable conflict of interest if they cater their reasoning and conclusions to find favour with religious or other authorities outside the committee, or fear spiritual sanctions if such authorities may find their independent conclusions scandalous or heretical. The power to challenge and contradict others, however high their authority, is characteristic of, and indispensable to the nature of, modern bioethical discourse. Bioethical judgments may, of course, be informed by

religious values, but cannot be required to be obedient to religious perceptions or doctrines.

References:

FIGO statement on an Ethical Framework for Gynecologic and Obstetric Care..

FIGO statement on The Role of the Ob/Gyn as Advocates for Women's Health.

FIGO statement on Ethical Aspects of Sexual and Reproductive Rights.

FIGO Ethical Guidelines on Conscientious Objection.

Caesarean Section on Request

Case:

Natalia, 37 years old, is pregnant for the first time. She works as an executive manager for a prominent publishing company. She is in good health but, after nearly two years of marriage without a desired pregnancy, she needed a mild treatment for ovulation induction in order to become pregnant. The follow-up of her pregnancy was uneventful. She knows by ultrasound that the baby is a boy. At 34 weeks, 7 ½ months, she discusses with her obstetrician the mode of delivery. Natalia wants to deliver by caesarean section. She argues that, at 37 years of age and with her demanding professional position, she may not have another child. She was the only child of her own family. She has waited so long for this precious baby that she does not want any harm occurring to him during labour or delivery. Above all, she confesses she is rather vain about her appearance and bodily integrity. She fears to suffer a future organ prolapse and urinary incontinence. She does not mind bearing a supra-pubic transverse scar, eventually removable with cosmetic surgery.

Questions:

Should Natalia's obstetrician comply with her request for caesarean delivery ?
 What are the obstetrician's ethical duties to Natalia if her request is not granted?
 Would it make an ethical difference if the procedure was funded under a public or a private health insurance plan ?

Assessment:

There is an increasing trend towards caesarean sections on request, for maternal preference, without any compelling medical indication. For instance, 31% of female obstetricians in the UK would request a caesarean section when they are pregnant, for the delivery of an uncomplicated singleton cephalic presentation at term. Their arguments are the fear of perineal damage from vaginal delivery, the fear of long term sequelae such as urinary stress incontinence and/or anal sphincter damage, the fear of long term effect on sexual function, and the fear of damage to the baby. Regarding obstetricians' attitudes in Europe to accept a woman's request and perform a caesarean section on demand, the lowest compliance of physicians is in Spain (14%), France (19%) and the Netherlands (22%), the highest is in Germany (75%) and the UK (79%).

However, both obstetricians and patients must be informed that, for an uncomplicated singleton pregnancy at term, the hazards of maternal mortality and of serious morbidity, i.e. pulmonary embolism, is three times higher after a caesarean section than after a vaginal delivery. In addition, for the neonate, the risk of respiratory disease or other neonatal complication may be 40 times higher after caesarean section compared to vaginal birth. Moreover, for the mother, a caesarean section does not guarantee against perineal damage. Urinary stress incontinence and genital organ prolapse are in part due to the pregnancy itself, and the physiologic relaxation of the perineal tissues, and are therefore unavoidable.

Ethical Analysis:

Respect for Persons:

The principle of autonomy provides that an individual is able to decide what is best for him-/her-self, including in the management of medical care, and is free to decide if a proposed treatment or strategy is acceptable or not. Any individual is entitled to refuse a surgical procedure proposed by a physician.

It does not mean, however, that an individual is entitled to impose a surgical procedure, such as a caesarean section, upon an obstetrician who is reluctant to perform it on request.

Benefit and Avoidance of Harm:

Any time a caesarean section is medically indicated, either for a maternal or a fetal condition, the benefit of the procedure surpasses its potential harm, and it is therefore ethically justified. Conversely, if a physician considers that the risk of a non-medically indicated caesarean section outweighs its benefits, the physician is ethically justified to refuse to perform it, in the name of conscientious objection. The physician then has a moral obligation to refer the patient to another obstetrician known usually to comply with such a request. A much-wanted, precious baby is not in itself an indication for a caesarean section, unless some are considered more precious than others, which would be ethically unacceptable.

Justice:

If Natalia intends to pay for the procedure from her own resources, it may appear comparable to cosmetic surgery, available as luxury medicine for those with the means and wish to avail themselves of the service. If management of her pregnancy is through publicly funded facilities, however, accommodation of her preference for caesarean delivery that is not medically indicated may make services unavailable or delayed for others in medical need, such as in emergency. Accordingly, her obstetrician and perhaps others responsible for the allocation of hospital or clinic resources will have to assess whether granting Natalia's wish for surgical delivery can be justified. Even if she is covering the costs from her own resources, the concern may arise of whether this deprives those dependent on the public provision of healthcare services of timely, skilled treatment. This points to a macroethical concern of the balance and interaction between concurrent public sector and private sector health services, especially when physicians work in both systems at the same time.

References:

FIGO statement on Ethical aspects regarding caesarean delivery for non medical reasons.

FIGO Ethical Guidelines on Conscientious Objection.

Choice of Home Birth

Case:

Marta, aged 28, gave birth to her two children, now aged 5 and 2, at the nearest hospital, 40 kilometres from her rural home, attended by the semi-retired resident obstetrician, Dr. Tien. Both births were relatively normal, the second with a few minor complications. Marta is now 6 months pregnant, with only a distant family history of twin births, and has asked if Dr. Tien can attend her delivery at home. She explains that her husband works long hours away from home, and she does not want to leave her two young children without proper care. Further, she finds that the family cannot afford the payment that hospital delivery and care would require. Dr. Tien lives near the hospital, and cannot easily travel 30 or more minutes to and from Marta's home.

Questions:

Can Dr. Tien ethically advise Marta that home birth is not as safe as hospital birth, and that she should find means to deliver in the hospital?

Should Dr. Tien ethically seek means to attend Marta's delivery at her home?

Can Dr. Tien ethically advise Marta to seek the care of a midwife or other adequately trained person such as a nurse to attend her delivery at home?

Assessment:

In many parts of the world, women have no choice but to give birth at home. Where women have a choice, high risk births are clearly better managed where necessary resources are available. For low-risk, normal births, a 1996 report by a WHO technical Working Group of the Department of Reproductive Health and Research found generally inconclusive data on the relative safety of health facility in contrast to managed home births. It has accordingly not been shown that home births present greater risks to women and/or infants than hospital births. Homes may not be as free from infection as sterile hospital settings, but hospital-born (nosocomial) infections do occur, as may errors, for instance of babies' identification, that home birth eliminates. In 2010, the European Court of Human Rights drew on this report to rule that a law interfering with physician's participation in women's choice of planned home births violates women's human rights to respect for their private lives.

Ethical Analysis:

Respect for Persons:

Dr. Tien's compliance with Marta's request would serve her autonomy, but Dr. Tien is an independent practitioner, and has no duty to comply with her request unless a pre-existing agreement has been made. Marta will remain autonomous to give birth at home without an obstetrician's attendance. She is vulnerable without adequate skilled assistance, however. Dr. Tien may therefore advise Marta on access to appropriately skilled aid, such as from a midwife or trained nurse who can manage home delivery, and ensure transport

to a hospital in the event of complications that cannot be adequately resolved at her home.

Benefit and Avoidance of Harm:

Whether or not Dr. Tien attends the home birth, attention should be paid to the guidance provided in the WHO report. This requires that preparation should be as comprehensive as circumstances allow, with a clean, adequate, warm space for delivery, clean water, careful hand washing, and warm cloths or towels to wrap around the baby. A suitable delivery kit is recommended by the WHO report, to maintain cleanliness and sterility, and give adequate treatment to the umbilical cord. Further, without causing Marta undue anxiety or appearing to try to persuade her to opt for hospital delivery, she should be informed that women at high risk of birth complications may not feel ill or show signs of distress, and that means of medical intervention in case of emergency concerning the mother and/or baby should be reviewed.

Justice:

Although the European Court of Human Rights has recognized women's privacy right to choose to give birth at home, the right, like many human rights, is probably a negative rather than a positive right. That is, although a state's laws may not interfere with physicians' and others' attendance at home births, there is no duty on anyone to facilitate them. States do have duties to provide for safe motherhood, and to have adequate hospital, clinic and related facilities and trained personnel available for this purpose, but they do not necessarily have to provide care for every home birth when women can access such facilities. Accordingly, Dr. Tien has no ethical duty to attend Marta's home birth, but has the choice to do so. Whether or not Dr. Tien should choose to comply with Marta's request, or alternatively to advise or ensure that she has a midwife's or other suitable attendance, with back-up access to the hospital in case of unexpected maternal and/or neonatal complications, is a matter of Dr. Tien's ethical judgment.

References:

FIGO statement on Home Birth.

FIGO statement on the Ethical Framework for Gynecologic and Obstetric Care.

FIGO statement on Safe Motherhood, 2006.

WHO Safe Motherhood, "Care in Normal Birth: a practical guide," 1996 (WHO/FRH/MSM/96.24).

Clinical Research

Case:

Dr. Curio is a sole general practitioner in a tropical area some distance away from any major city. An overseas pharmaceutical company has contacted Dr. Curio to enquire whether the doctor would participate in a research study to test a new drug intended to improve treatment of a tropical disease common in the area where the doctor practises. Dr. Curio's tasks would be to recruit a number of patients as research subjects, monitor their reactions to the experimental treatment and report findings to the appointed research administrator. Dr. Curio could select in return either a financial payment or a free supply of company products, based on the number of patients recruited.

Questions:

Can the doctor ethically recruit the doctor's own patients as subjects of this research study?

Would Dr. Curio be in a conflict of interest by accepting financial payment for entering patients in the study?

Would acceptance of free pharmaceutical products for patients ethically justify Dr. Curio's participation in the study?

Would Dr. Curio's participation in the study entitle the doctor to co-authorship of the study's published results?

Assessment:

Research reverses the traditional doctor-patient relationship. In that relationship, the doctor serves the needs of the patient, whereas in research, the research subject serves the needs of the investigator. When a doctor becomes an investigator, and the doctor's own patient becomes a subject of research, it may not be clear to the patient, or to the doctor, that their relationship is different, and reversed. The requirements of the patient/subject's informed consent are also different, in that a potential research subject must be informed that a proposed new treatment is unproven, with undetermined risks and side-effects, and that there is the choice of having the therapeutic treatment that is usually recommended.. Further, although research subjects have been expected to act altruistically, there is growing ethical discussion of whether, unlike patients, they may or should receive financial payment. It is expected that research subjects should receive care for their medical needs without payment, including care for conditions separate from those for which they serve as research subjects. In some circumstances, such as when research subjects come from environments deprived of health services, it may be ethically required that the general health care needs of research subjects be met.

Ethical Analysis:

Respect for Persons:

Respect for patients requires that Dr. Curio should inform patients of any proposal to treat them not according to the doctor's disinterested view of their best interests, but according to the requirements of a research protocol. Respect also requires that the doctor takes active steps to disabuse them of the "therapeutic misconception" to which they are liable to be prone, namely, that any form of treatment the doctor proposes is intended primarily for, and likely to achieve, their benefit.

As patients, they are vulnerable to Dr. Curio's suggestion of what treatment they should receive. There is not necessarily a contradiction between Dr. Curio's recommendation that patients should receive the study drug and the doctor's genuine conviction that such treatment is in the patients' best interests, depending on the therapeutic options available to patients. However, patients may lack access to an independent opinion of where their best interests lie, and lack means independently to assess whether Dr. Curio's disclosure of benefits derived from the doctor's and their own participation in the study resolves any conflict of interest that may affect the doctor's recommendation.

Benefit and Avoidance of Harm:

Independent ethics review of a clinical research proposal should assess whether it offers a sufficiently favourable therapeutic or other benefit to justify its risks. If it does, it must still be determined to what or whom the benefit relates, and who bears the risks. The risk-bearer is usually the research subject, who may be a patient coming to the doctor for care. If the study promises to benefit this and/or other patients proportionately to the risks that informed patients are competent to accept, it can be considered therapeutically or otherwise beneficial.

The benefits the study offers to Dr. Curio are financial payments or free pharmaceutical products. If the doctor applies money income to subsidize treatment of poor patients, or makes indicated drugs available to patients without charge, this may be considered beneficial. If, however, payment goes to the doctor's personal enrichment, or the doctor sells pharmaceutical gifts for profit, patients may not benefit if they accept the risks of an unproven (although not necessarily harmful) treatment.

Justice:

Concern regarding justice arises from the power imbalance between doctors and their patients. A doctor often has considerable authority over the patient's access to appropriate care, and sick patients dependent on their doctors for treatment may feel unable to act contrary to their doctors' expressed or implied preferences. The initial ethical understanding is that doctors should not seek to recruit their own patients as subjects of research, because patients may feel obliged to comply with their doctors' requests or suggestions. Doctors should not request favours from their dependent patients. However, doctors have to pursue their patients' best interests, and Dr. Curio may feel in good faith that patients would be better served by entering the study because of the benefits to them. The benefits Dr. Curio may derive may have to be disclosed, but

this may create pressure that patients feel not to deny the doctor such benefits by declining the doctor's request to take the new product and asking instead for the usual, non-experimental treatment. Dr. Curio's patients may not have access to independent advice when offered a choice between usual and alternative, experimental, treatment.

References:

FIGO statement on Just inclusion of women of reproductive age in research..

FIGO Guidelines for physicians' relationships with industry.

World Medical Association Declaration of Helsinki : Ethical Principles for Medical Research Involving Human Subjects, as amended 2008.

B.M.Dickens, R.J. Cook,. Challenges of ethical research in resource-poor settings. Int J. Gynecol Obstet 2003; 80 (1): 79-86.

Conflict of Interest

Case:

Dr. Medico owns the two-storey building near the town centre where his busy gynecological practice is located on the upper floor. The street-level floor is rented including to a pharmacy business of which Dr. Medico is a 40% proprietor. The business employs three pharmacists and is open 24 hours a day, returning a sizeable profit.

Dr. Medico writes many prescriptions for drugs, and advises patients on non-prescription products and devices they may use. Many of his patients take their prescriptions to the ground floor pharmacy to be dispensed. Dr. Medico does not inform his patients of his interest in the pharmacy, unless they ask for his recommendation.

When an officer of the medical licensing authority asked Dr. Medico about his interest in the pharmacy, he said that it is primarily to ensure the quality and convenience of its services and that its pricing policies are sensitive to the local community's income level. He also explained that he does not inform patients of his interest in the pharmacy, unless they ask for a recommendation, in case they see this as requiring them to use this pharmacy rather than others.

Questions:

Should doctors be allowed to have financial interests in dispensing pharmacies?

Should doctors be allowed to rent premises near their offices to dispensing pharmacies?

Should Dr. Medico volunteer information to all his patients of his influence over the ground floor pharmacy?

Should Dr. Medico be allowed to inform patients who ask for his recommendation about his influence over and financial interest in the ground floor pharmacy?

Should doctors who are not prohibited seek the approval of their licensing authorities and/or professional associations before they take financial interests in, or rent space to, dispensing pharmacies?

Assessment:

Studies have shown that doctors with financial interests in pharmacies and clinical laboratories write more prescriptions and order more tests per 100 patients than those without such interests. Some medical licensing authorities prohibit doctors from having financial interests in pharmacies and/or clinical laboratories and from renting space to them near their own offices, as constituting a conflict of interest. Studies also show that

some pharmacies lacking medical supervision have higher rates of dispensing errors than those that are under medical supervision.

Ethical Analysis:

Respect for Persons:

Dr. Medico's patients retain autonomy to have their prescriptions dispensed wherever they want. Those who use the ground floor pharmacy do not know that their prescriptions and other purchases may benefit Dr. Medico. Some might prefer to take their prescriptions to a pharmacy under his influence, if they are confident that proper standards of dispensing will be maintained. Patients uncertain where to go who request Dr. Medico's recommendation, will be told of his influence over the ground floor pharmacy.

Benefit and Avoidance of Harm :

Some patients may find it convenient to use the ground floor pharmacy if they live nearby. Those living further away may prefer to use pharmacies closer to their homes. Dr. Medico applies no pressure or influence over patients' choices, but assists those who request advice.

Justice:

Patients are treated equally in that Dr. Medico does not volunteer information of his interest in the pharmacy. Only those who request a recommendation for a reliable pharmacy will be informed. Uninformed patients may go elsewhere, chancing that the services they receive are less reliable. Dr. Medico does not distort fair competition among pharmacies by directing his patients to the ground floor business.

References:

FIGO Guidelines for Physician Relationships with Industry.

H.Brody. Clarifying Conflict of Interest. American Journal of Bioethics, 2011; 11(1): 23-28

R.G.Speece, D.S.Shimm, A.E.Buchanan (editors). Conflicts of Interest in Clinical Practice and Research – New York: Oxford University Press, 1996.

T.L.Carson , Conflicts of Interest and Self-Dealing in the Profession. Business Ethics Quarterly 2004; 14(1): 161-182.

Cost Containment

Case:

Dr. Techno, on the medical staff of City Centre Hospital, is concerned about Rosa, a 27-year old patient about 8 weeks pregnant who is complaining of abdominal pain. Dr. Techno cannot identify the cause, and Rosa, a qualified nurse, asks Dr. Techno to order a computed tomography (CT) scan, available from the low-dose equipment at the hospital. Dr. Techno considers this desirable and safe for Rosa's pregnancy, but is under pressure from the hospital administration to be economic in use of this costly procedure. The local medical association has also urged practitioners to reduce unnecessary resort to CT scans, and the governmental ministry funding the hospital has threatened to limit funding if running expenses are not contained.

Questions:

Is Dr. Techno ethically obliged to comply with Rosa's request and order a CT scan?

Can Dr. Techno ethically advise Rosa that the Scan is not strictly necessary for her, and decline to order it?

Can Dr. Techno consult with a colleague not responsible for Rosa's care, and reach a joint decision on whether or not to order a CT scan?

Can Dr. Techno exercise clinical judgment to order the CT scan, but invite the hospital administration to veto the decision on grounds of economy?

Assessment:

Where reserves on which a population of current and potential patients depends for health care are scarce, a physician or other provider is liable to face the dilemma of acting in what is considered an individual patient's best interests, without regard to the effect on other equally dependent patients, or to subordinate that patient's interests to what is considered the general good. The dilemma of double agency arises when an individual health care provider is required to serve a particular patient with integrity and fidelity, but also to serve the interests of a more general population of that provider's and colleagues' other patients in making a rational use of scarce community resources. The microethical expectation of allegiance to the individual patient, sometimes shared by courts of law, requires application of clinical judgment in that patient's interests alone, but a macroethical duty requires care for the wider community of patients.

Ethical Analysis:

Respect for Persons.

Ethically, Rosa's autonomy would be served by order of the CT scan. The order would also be consistent with not exploiting her vulnerability and dependency, that is by not sacrificing her interests to those of other patients. Other patients are vulnerable too, but

Dr. Techno's decision should be based only on what the doctor considers, in clinical judgment, to be in Rosa's best interests in appropriate diagnosis of her condition, if her autonomy is to have priority.

Benefit and Avoidance of Harm:

Dr. Techno must assess whether Rosa's beneficial access to diagnosis by CT scan would risk any radiation-related harm to the embryo or fetus she carries, and whether such risk is outweighed by the advantage to her pregnancy of successfully diagnosing the cause of her abdominal pain. A further assessment Dr. Techno must make is whether ordering a CT scan for Rosa, though desirable, is so necessary or beneficial as ethically to justify denying the scan to another patient, who may be one for whose care Dr. Techno is also responsible. This would present the doctor not with a conflict of self-interest, but with a conflict of commitment. That is, the doctor would have no personal benefit in favouring Rosa over another patient or vice-versa, but might have ethically to justify withholding an indicated CT scan from one patient while making it available to another. If the benefit of having a CT scan, and the harm of being denied a CT scan, are ethically equal between the patients, Dr. Techno might decide by random chance, such as by flipping a coin, which would give the competing patients an equal chance.

Justice:

Dr. Techno might complain of the injustice of having to decide to benefit one patient, such as Rosa, at the cost of another. It may also have to be resolved whether it is just to favour a pregnant patient over one who is not pregnant, or to disfavour a pregnant patient when her unrelated chances of not surviving pregnancy are lower, such as in settings with relatively high rates of maternal mortality. Dr. Techno might claim an entitlement to use whatever available resources are indicated for Rosa's care, and leave the burden of achieving departmental or hospital economy to an independent manager, such as by making the resources unavailable. That is, Dr. Techno may protest against the injustice and breach of ethics of being forced to act as a double agent.

References:

FIGO statement on The Role of the Obs/Gyn as an Advocate for Women's Health.

FIGO statement on the Ethical Framework for Gynecologic and Obstetric Care.

FIGO statement on Safe Motherhood.

Egg Donation

Case:

Mrs Gage, 42 years old and childless, is desperate to conceive, after 5 years of trying without success, although her husband has a normal sperm count. Mrs. Gage has suffered two miscarriages at 8 and 9 weeks. In consultation with Dr. Vita at a fertility clinic, Mrs. Gage decides that she requires an ovum donor, but explains that neither she nor her husband have family members or friends who are suitable to donate. Mrs. Gage's antral follicle count and AMH both point to a very low ovarian reserve, but she has no other medical problems. Ultrasound showed her uterus to be normal, and she is in good health, with no contraindication to pregnancy. Mrs Gage had emigrated from a country where professional ethics requires ovum donation to be uncompensated and anonymous. She lives in her husband's native country, where donation may be compensated within legally regulated limits, but where professional ethics requires that, on becoming of age, children born of gamete donation be able to learn the donors' names. Dr. Vita says that an adult woman recruited from either country can be the donor, but ovum transfer between the countries is illegal. Mrs. Gage says that she would like Dr. Vita to find a suitable, anonymous donor.

Questions:

Can Dr. Vita ethically bring in a compensated donor from Mrs.Gage's native country?

Can Dr. Vita ethically maintain anonymity of a donor from Mrs. Gage's native country?

Can Dr. Vita ethically advise a potential ovum donor?

Should Dr.Vita ethically advise Mrs.Gage to seek services in her native country?

Are there special medical considerations of which Dr.Vita should ethically advise Mrs.Gage in bringing in a donor from another country, or in Mrs.Gage obtaining services in another country?

Does Dr. Vita have an ethical duty to seek Mr. Gage's independent preferences?

Assessment:

Female fertility declines with age, especially after 35 and even more rapidly after 40. Premature ovarian failure occurs in 1-2 % women, but decreased ovarian reserve is probably more common. The success rate of pregnancy following ovum donation is almost 50%, but there are slightly increased risks of pregnancy complications including bleeding during delivery and post partum. The ovum donor will go through IVF stimulation, which carries a minor risk of ovarian hyperstimulation syndrome (OHSS), and in some countries may be compensated for donation, usually within regulated limits. In some countries, such as France, the donor must be totally anonymous, but elsewhere, such as in the UK, parents must undertake to make donors' names available on request to their offspring when they reach majority age.

Individuals seeking and offering reproductive care services across national borders is a relatively recent phenomenon, the implications of which are being progressively revealed based on experience, anecdotes and empirical data. The implications of the phenomenon in medical ethics are also under progressive recognition and assessment, disclosed, for instance, in statements, guidelines and recommendations issued by professional and academic bodies.

Ethical Analysis:

Respect for Persons:

If Dr. Vita endorses Mrs. Gage's decision to seek an ovum donor, and identifies means of successful recruitment, her desperation to become a parent may diminish her capacity for autonomous choice regarding most appropriate alternative in her circumstances, amongst which are abandoning treatment, and adoption. To promote her autonomy, these alternatives should be explained to her by a disinterested counsellor. This raises the ethical issue of whether Dr. Vita is disinterested. A further ethical issue is whether Dr. Vita has any accountability to Mr. Gage in treating Mrs. Gage.

For the donor, there is the risk of her autonomous choice of donation being subverted by the inducement of an apparently high level of payment. If she is in need of money, she may be vulnerable, and in need of independent advice on the risks of undergoing donation, such as of OHSS. Dr. Vita's primary duties are to Mrs. Gage, raising the ethical concern of whether the doctor can at the same time treat and advise the prospective donor as a patient.

Benefit and Avoidance of Harm:

For many women with access to reliable maternal health care, the benefit of becoming a parent far outweighs the risks inherent in any pregnancy, although the risk is slightly higher than normal for Mrs Gage if she receives one or more donated ova. An ethical issue is whether Dr. Vita needs to take account of whether Mr. Gage would see his wife's pregnancy and motherhood as a benefit.

A potential ovum donor would have to assess the benefit to her of paid or altruistic donation against the risks of suffering harm, minimal as they usually are (OHSS, bleeding, infection at ovum retrieval). Disinterested, informed counselling is essential for the donor's understanding of all potential implications of her donation, both beneficial and harmful, including knowing that another woman may be rearing her biological child, and that in years to come that child may contact her. The risks of repeated donation are unknown at present.

Justice:

In most countries where donation is practiced, there is a severe scarcity of donated ova compared to the demand. An ethical issue is whether donated ova can justly be allocated to former cancer sufferers or, for instance, Turner syndrome sufferers, in priority to older women who might have conceived with their own ova if younger. This may place the ethics of maximum use of scarce medical resources and the human right of non-discrimination on grounds of disability in competition with each other. Furthermore,

many women travel to other countries for ovum donation because at home it is legally forbidden or there are lengthy waiting lists. This may deprive citizens of the countries to which they go of medical care, especially if they are resource-poor countries that do not offer citizens all basic health care. This may aggravate international health care inequalities, while at the same time bringing valuable income to poor countries that may be fairly distributed within the health sector.

References:

FIGO statement on Ethical Aspects of Gamete Donation from Known Donors (Directed Donation)

FIGO statement on Cross- Border Reproductive Services.

Female Genital Cutting / Mutilation (FGM)

Case:

Kani, aged 20, married for two years, reported to Dr Magum that she had been unable to conceive. She had marital problems, and was about to be divorced because of her inability to become pregnant.

On examining her, Dr.Magum found that the marriage had not been consummated due to infibulation, the most severe form of FGM, performed on her by a midwife when Kani was aged seven. She also had a swelling resulting from this traditional practice which was causing her a great deal of inconvenience.

Questions:

What should Dr. Magum ethically propose for Kani's benefit ?

Does Dr. Magum have an ethical duty to explain to Kani's husband why the marriage has not been consummated ?

Does Dr. Magum have an ethical duty to seek and report the identity of the midwife who performed the procedure ?

Does Dr.Magum have an ethical duty to the family and/or community from which Kani came to give instruction on the harms of FGM ?

Assessment:

The case of Kani illustrates the health risks that can be inflicted by the harmful traditional practice of female genital cutting, often described as mutilation (FGM). This practice, which is not based in any religion, is prevalent in a number of countries, mainly in sub-Saharan Africa. It is now also seen in Europe, North America and other countries among populations that have migrated from affected regions. Many young girls are subjected to the practice, which is a violation of the rights of the child. If performed by medical or other health professionals, the practice is usually taken to constitute professional misconduct.

The consequences to Kani were a tumour (dermoid cyst) and tight infibulation, which is preventing the consummation of her marriage, resulting in infertility. The emotional and marital damage to Kani is great, and could cause her to be divorced. She may also suffer additional burdens of ill health due to complications of infibulations..

Ethical Analysis:

Respect for Persons:

When undertaken on young children incapable of exercising choice, female genital cutting exploits their vulnerability, and constitutes violation of their rights, such as to health. It is ethically questionable whether younger adolescents who accept the procedure as a rite of passage into adulthood in their communities are really exercising their autonomy when they are subjected to family and community pressures they lack means to resist. However, the wishes of adult women capable of autonomy who have conceived and given birth after being unstitched, and who then request reinfibulation, may be

respected, although this is professionally condemned on health grounds and as risking condoning an earlier wrong.

Although used, for instance, by WHO, the description “mutilation” is ethically problematic. Infibulation, as the most severe genital procedure, may warrant this description, but lesser forms of token genital cutting may be unjustly condemned by this word. Among communities that have traditionally undertaken this practice, it is often explained as a form of purification. Female genital cutting risks and often causes multiple harms, so belief in its appropriateness appears misguided. However, the belief may not justify a description designed to draw disrespect and condemnation upon caring parents who have been conditioned by their culture to accept it.

Benefit and Avoidance of Harm:

It would appear beneficial to Kani if Dr. Magum, by appropriate means, rendered her capable of sexual intercourse with her husband, with a view to creating a family. Beyond this, Dr. Magum would promote the couple’s greater benefit by explaining to them, preferably together but separately if their culture disallows discussion of sexual matters in mixed company, the means of sexually expressing intimacy and love. Kani’s husband may know about sex from older men, perhaps in crude terms, and before marriage Kani’s mother or close female family members may have told her, perhaps in euphemistic terms, about a wife’s expected submission to her husband. A disadvantage of such information is that it may incorporate inaccuracies, folklore, myths, and dysfunctional stereotypes. It is preferable that Dr. Magum should provide the information that, with treatment and understanding, they may not be an infertile couple, but may realistically look forward to having a family together.

For avoidance of future harm, Dr. Magum may also inform them of the physical and emotional harm to which female genital cutting often leads, and that it should not be conducted on a daughter or other female family member of theirs. To maximize the benefit of this education, Dr. Magum should consider providing information to them individually, jointly, and/or communally.

Justice:

If local law requires reporting of known instances and perpetrators of female genital cutting, Dr. Magum may be required reasonably to seek the identity of the person acting on Kani, and to inform appropriate law enforcement and/or professional licensing authorities. If no such duty exists, the doctor may have a discretion in good faith to report misconduct to professional authorities, and child abuse to law enforcement authorities, although this may place Kani’s parents at risk.

At the level of social justice, Dr. Magum should consider initiating or contributing to community education on the harm and wrong of female genital cutting, and urge its eradication from the community and culture in order to spare future children from suffering this unnecessary injury. The doctor may try to enlist the aid of religious and other community leaders in this endeavour.

References:

FIGO statement on Female Genital Cutting

FIGO Ethics statement on The Role of OB/GYNs as Advocates for Women's Health, 1999

R.J.Cook, B.M.Dickens, M.F.Fathalla, Female Genital Cutting (Mutilation/Circumcision): Ethical and Legal Dimensions Int. J. Gynecol. Obstet 2002; 79(3): 281-7.

Hepatitis B Vaccination

Case:

Dr. Adams, a clinician and influential consultant to the government medical insurance plan in a developing country with low resources, conducts routine antenatal screening on Eve, a 30-year-old HIV-positive pregnant patient with a CD4 count of 950 and undetectable viral load (on antiretroviral therapy). Dr. Adams found Eve to be Hepatitis B surface antigen positive (HBs +ve) and Hepatitis e antigen positive (HBe +ve) with no antibodies to both surface and e antigens. Her liver function tests are completely normal. She is classified as a chronic carrier of Hepatitis B. What are Dr. Adams ethical choices in advising Eve, and in making recommendations to the government medical insurance plan?

Questions

Should Dr. Adams ethically recommend that the pregnancy continue, when local law would allow its termination?

Should Dr. Adams ethically recommend that Eve deliver by caesarean section, and that all other pregnant patients chronically infected with Hep B deliver in the same way?

In Dr. Adams' developing country where HIV is highly prevalent, should all HIV-positive individuals be tested for Hep B, and vaccinated when they test positive?

Should Dr. Adams recommend that vaccination for Hep B be a prescribed minimum benefit under the government medical insurance plan?

Assessment

The Hepatitis B virus is one of the most common human pathogens worldwide. Up to 95% of HIV-infected individuals have been infected with Hep B. Sexual transmission is the most common route of transmission. In pregnancy, most transmission of Hepatitis B virus infection occurs around the time of delivery through contact with contaminated vaginal secretions or blood. HIV/Hep B co-infection increases liver mortality 15 times more in than in an HIV negative individual. Progression to hepato-cellular carcinoma is increased by 5 times especially in patients with chronic Hepatitis B. All patients infected with HIV but negative for Hep B should be vaccinated. Approximately 30% of HIV infected patients have a non-response. The response to the vaccine is influenced by the CD4 count and the level of HIV. Patients with CD4 less than 200 and who are not on therapy should receive ARVs first and then be vaccinated when there is a good response to ARVs.

Ethical Analysis:

Respect for Persons:

Dr. Adams may advise Eve who is HIV-positive to continue with her pregnancy since her liver function was normal, but it would be entirely be up to her to decide whether she should opt for the termination of pregnancy or carry her baby to term, bearing in mind that being HIV-positive and an Hep B carrier can transmit the virus to her newborn during pregnancy or delivery.

While autonomy entails respecting the rights of other individuals to freely determine their own choices and decisions, Eve and other patients with the same condition are vulnerable to liver disease and respect for persons necessitates Dr. Adams to arrange that such patients be also seen by a liver specialist.

Benefit and Avoidance of Harm:

On the basis of the principle of *Beneficence*, it may be plausible to have all patients infected with HIV but negative for Hep B vaccinated. However, it is to be noted that approximately 30% of HIV infected patients have a non-response in view of the fact that response to the vaccine is influenced by the CD4 count and the level of HIV. Patients with CD4 less than 200 and who are not on therapy should therefore receive ARVs first and then be vaccinated when there is a good response to ARVs.

Moreover, it is to be noted that in pregnancy most transmission of Hepatitis B virus infection occurs around the time of delivery through contact with contaminated vaginal secretions or blood. It may be sound on the part Dr Adams to recommend that Eve deliver by caesarean section, and that all other pregnant patients chronically infected with Hep B deliver in the same way. Furthermore, in order to avoid harm, Eve's newborn child must be given two shots in the delivery room - the first dose of Hepatitis B vaccine and one dose of Hepatitis B immune globulin (HBIG). If these two medications are given correctly within the first 12 hours of life, a newborn has a 95% chance of being protected against a lifelong Hepatitis B infection. The infant will need additional doses of Hepatitis B vaccine at one and six months of age to provide complete protection.

Justice:

On the societal level, while taking into account that Hepatitis B is not transmitted casually and that it cannot be spread through sneezing, coughing, hugging, or eating food prepared by someone who is infected with Hepatitis B, it would be justified to make members of a household aware that there is an infected family member living in their household and that they should be vaccinated.

Dr. Adams should definitely recommend that vaccination for Hep B be a prescribed minimum benefit under the government medical insurance plan for that would be cost effective in the long run and would also circumvent vulnerable females from contracting liver cancer.

References:

Hepatitis B Guidelines for Pregnant Women. <http://www.hepb.org/pdf/pregnancy.pdf>.

Hepatitis B Foundation at www.hepb.org.

National Immunization Programme at www.cdc.gov/hepatitis.

Human Papilloma Virus (HPV) Vaccination

Case:

Dr. Physio is medical officer for a school for children of both sexes aged 5 to 15. There is a high rate of cervical cancer in the region, which has orphaned several of the children. The local government has introduced a preventive programme of human papillomavirus (HPV) vaccination for schoolgirls aged from 9 years upwards. The school principal asks Dr. Physio how pupils at the school can receive maximum protection.

Questions:

What should Dr. Physio advise?

What should parents be told?

What should schoolgirls be told?

What account should be taken of schoolgirls' wishes?

Can vaccination of schoolgirls be compulsory?

Should schoolboys be treated in the same way as schoolgirls?

Assessment:

In 2006, a vaccine against the oncogenic types 16 and 18 of HPV was licensed. A number of countries have recommended vaccination of girls between the ages of 11 to 17 with catch up vaccination up to age 26. There is limited data on the safety and efficacy of the vaccine in some circumstances, and on failure to have follow-up vaccination. Most sexually active people will contract HPV at some time in their lives, usually with no awareness or effects, but it can dispose women to eventual cervical cancer, and premature death. Protection by HPV vaccination is most effective when it is undertaken before girls' first sexual intercourse. The interaction between HIV and HPV is complex. Warts are more common in HIV-positive than in HIV-negative patients. There is evidence that HPV infection in HIV-positive patients progresses to dysplasia and cervical cancer.

Ethical Analysis:

Respect for Persons:

Dr Physio may advise the school principal to consider implementing HPV vaccination for girls at the school above a given age, such as 11, to inform girls' parents and guardians of the school's intended programme of vaccination, and to request their consent. The autonomy of parents or guardians (hereafter "parents") over the children for whose well-being they are responsible is not absolute, because parents are bound by ethical and often legal duties to protect vulnerable children, and to make decisions concerning them, including regarding their health and welfare, in their best interests.

The capacity of children to make choices regarding their health care will frequently be influenced by the cultural background of the families concerned. Laws often set ages beneath which legal minors lack capacity, for instance to purchase tobacco products or drive motor vehicles, but many accept that “mature minors” may make therapeutic and preventive health care decisions for themselves. They may decline treatment their parents approve, and in particular give effective consent to beneficial or protective medical treatment without parental consent. It is an ethical decision whether mature minors should be offered protective medical procedures without parental approval, and whether mature minors’ confidentiality should be respected, so that they choose whether their parents are informed.

Benefit and Avoidance of Harm:

Parents may be slow to acknowledge that their young daughters, like all members of the human species, are sexual beings, and that they may become sexually active before parents believe they will. Parents should be told that consenting to vaccination of their daughters is in the best interest of their children’s protection, that vaccination is proposed for them before they decide to become sexually active, and that it could well serve as a protection for them in the event of sexual assault. Schoolgirls should be made aware that the HPV vaccine is a preventive measure against cervical cancer.

Parents and others may believe that administering such a vaccine to prevent adolescent girls from contracting a sexually transmitted virus could promote their sexual promiscuity, and hence the principle of *nonmaleficence* would justify non-administration of HPV vaccination. However, it may be unlikely that teenage girls would give the risk of their contracting HPV the same weight as they give to the risk of pregnancy in their choices to engage in sexual activity. The actual benefit of HPV vaccination for adolescent girls would far outweigh the potential harm of vaccination contributing to their sexual precociousness. In light of this, such vaccination may be made compulsory by the state if it is of the view that relying exclusively upon parental autonomy could be harmful to the children’s health and welfare. For example, parents may suggest that such vaccination should be given only to daughters who are above compulsory schoolage, for instance, 15 or 16 years old. Therefore, to promote preventive care for minors, the state may require vaccination of preadolescent girls while they are conveniently gathered in schools. The vaccine is effective only if administered prior to girls’ exposure to the virus and will not treat existing infections, but may serve to reduce the eventual harm, to women and others, such as their children, of women succumbing to cervical cancer. Hence, the state and schools may justify compulsory HPV vaccination of preadolescent girls before they indulge in any form of sexual activity, including sexual contact without intercourse.

Justice:

Since the principle of *justice* entails treating both girls and boys alike, it logically follows that preadolescent boys as well as girls should be vaccinated for HPV, particularly since females contract the infection from males. However, a new and an accompanying editorial published online (October 8, 2009) in the *British Medical Journal* suggests that vaccinating boys against HPV in addition to girls is not likely to be cost-effective. This raises the issue of whether there is an ethically relevant difference between the sexes in this regard.

References:

FIGO statement on HPV Vaccination and Screening to Eliminate Cervical Cancer.

FIGO statement on Adolescent and Youth Reproductive Health Care and Confidentiality.

<http://www.articledashboard.com/Article/The-HPV-vaccine--Why-it-won-t-promote-sexual-promiscuity/499930>.

<http://www.medscape.com/viewarticle/710362>

Hysterectomy

Case:

Luz is 41 years old, and works in customer service at a department store. She is unmarried, but for many years has enjoyed an active sexual relationship with her 43-year-old manfriend. Her mother died of cervical cancer twenty years ago, as did her older sister three years ago.

Luz has suffered uterine bleeding for the last three years due to multiple uterine leiomyomas, and is slightly anemic. She does not want children. She came to visit a Gynecologist, Dr. Perez, who had cared for her older sister, knowing from her own reading and research that hysterectomy is the best treatment alternative for her pathology. However, she does not want her uterine cervix removed, and wants no changes in her sexuality or capacity for sexual enjoyment. Doctor Perez said that she needs a total abdominal hysterectomy, and argued that since cervical cancer is the most frequent women's cancer in the country, her uterine cervix should not be retained for any reason. Doctor Perez works for the governmental Social Security medical service, but Luz belongs to a private health insurance plan. Under its terms, she went to a private gynecologist, Dr. Salas, who explained that a subtotal hysterectomy is an alternative treatment, since Luz has had normal Pap smears throughout her reproductive life. Dr. Salas emphasized her need to continue to have annual Pap smears.

Questions:

Should Dr. Perez have asked Luz about her sexuality before addressing the treatment options and making a recommendation?

Should the patient's preferences and reasons and the reasoning of Dr. Perez have been balanced against each other before a decision on a surgical technique was made?

Should Dr. Salas have taken account of the patient's liability to suffer cervical cancer?

What is the ethical significance of Luz's family history of cervical cancer deaths?

Assessment:

In the 1950s, improvements in surgical technique and the desire to prevent cervical cancer resulted in the adoption of routine removal of the cervix with the rest of the uterus at the time of hysterectomy. Currently, there is a resurgence of interest in leaving the cervix in place at the time of hysterectomy.

In 1983, Kilkku published a study showing more frequent orgasms after supracervical hysterectomy than after total hysterectomy. It was argued that the nerves in the cervix are important for orgasm. This was a retrospective study in which there was no baseline assessment of the subjects, so it is impossible to draw any meaningful conclusion.

Although we have very good screening methods for cervical cancer, adenocarcinoma is increasing in frequency. There is a small but definite risk of cancer in a remaining cervix.

Masters and Johnson's pioneering studies of the female sexual response suggested that, at least in some women, the uterus plays a role in the physiology of vaginal orgasm, so the supracervical hysterectomy, by preserving nerves and ligaments, helps to preserve normal postoperative sexual function. Some authors in reviewing the arguments remain unconvinced of these purported advantages.

Recently, in 2010, Dr Ellström, published a randomized clinical trial, comparing changes in sexual health between women with subtotal and total hysterectomies, and concluded that "women undergoing subtotal hysterectomy experience a greater positive change in the frequency of orgasm and extent sexual pleasure after surgery than women undergoing total hysterectomy."

Ethical Analysis:

Respect for Persons:

The first doctor Luz visited took relatively slight account of the principle of autonomy, giving greater attention to saving her from the risk of cervical cancer. However, Luz was reading and obtaining information about her pathology and the treatment options. Dr Perez made a recommendation based on what health care intervention will be the best for her, considering biological reasons, rather than based on her enjoyment of her sexuality, or on the treatment's psychological implications for her.

Benefit and Avoidance of Harm:

The gynecologist Dr. Perez thought to benefit and protect the patient's physical health, but performing a total abdominal hysterectomy may harm the patient's sexual and psychological health, and affect the quality of her relationship with her manfriend..

Justice:

Luz could be offered a subtotal hysterectomy because she has means to be a member of a private health insurance plan. Other similarly situated women who have only dependency on the Social Security medical service plan might not have the option of the surgical procedure that they reasonably want. They might be confined only to care such as Dr. Perez offered. Under the principle of justice, the quality of life and the well-being of each person should be taken equally into account.

References:

FIGO Recommendations on ethical issues in obstetrics and gynecology by The FIGO committee for the ethical aspects of human reproduction and women's health.

FIGO Guidelines regarding informed consent.

E.Ellström , K. Jerhame, A randomized trial comparing changes in sexual health and psychological well being after subtotal and total hysterectomies. *Acta Obstet Gynecol Scand.* 2010; 89(1):65-70.

Illiterate Patients' Informed Consent

Case:

Anna, aged 24, resident in a resource-poor rural area, is about 20 weeks into her second pregnancy. Her first child, aged 3, was delivered vaginally after a complicated pregnancy. Her present pregnancy is also proving difficult, and her doctor, Dr. Nomina, is considering whether an episiotomy or a cesarean delivery may be necessary, and if so, which Anna would prefer. Anna and her husband are unable to read, fearful of Anna being cut, and intend to have several subsequent children. Dr. Nomina has shown them illustrations of the two procedures, and is concerned whether Anna and her husband adequately understand the implications of their choices. The doctor does not want them aggrieved after the second child's birth that they were not informed about how delivery might be managed, the effect on their resumption of love-making, and on subsequent deliveries.

Questions:

Can Anna and her husband exercise choice of preference?

How can Dr. Nomina maximize the understanding Anna and her husband have of options that may arise?

How can Dr. Nomina ethically minimize grievance that Anna's options were not adequately explained?

Can Dr. Nomina ethically compromise best care of Anna in order to accommodate her preference?

Assessment:

Both episiotomy and cesarean delivery may leave scar tissue, cause discomfort, risk infection, and may affect subsequent deliveries. Though better avoided if possible, a choice of one option or the other may prove necessary to facilitate safe delivery and reduce delivery-related injuries to newborns. Aftercare of mothers may require skilled attention, such as by midwives. Counselling in anticipation may be aided by patients consulting with women who have experienced these procedures and, subject to preservation of confidentiality, patients' comprehension and expression of preferences may be witnessed by independent third parties before notation of their choices in patients' medical records

Ethical Analysis:

Respect for persons:

Patients' illiteracy does not deny them the right of choice or capacity for making competent decisions. However, their dependence on oral communication limits their access to more information than they can be told and can remember, which leaves them vulnerable to bias in presentation and distortions of memory, and their inability to

maintain their decisions in writing leaves them vulnerable to others' recording of what they decide. Disinterested witnesses might reliably show that patients received information, had opportunities to ask questions, and made particular decisions or choices, but at the cost of patients' rights to confidentiality.

Benefit and Avoidance of Harm:

It is of benefit to patients that they be facilitated, by means they comprehend, to assess their options and make their decisions, although patients' power of self determination may result in them making adequately informed but unwise, potentially harmful decisions. Healthcare providers' initiatives to protect patients against their poor choices by actions patients do not comprehend and to which they therefore do not give their informed consent, may be well intended, but are paternalistic and offensive to patients' dignity as decision-makers over their own bodies and health.

Justice:

The integrity of Dr. Nomina's disclosures to Anna, and of Anna's unimpaired exercise of choice, may be confirmed by a disinterested third-party witness, but the primary purpose of the witness is to protect Dr. Nomina against a subsequent charge of acting without consent or contrary to Anna's wishes. That is, Anna may be encouraged to forgo her right to confidentiality by introduction of a third party witness, in order to protect not her but the doctor's interests. Dr. Nomina is entitled to protection against allegations of misconduct, but it is of ethical concern when doctors and similar actors who enjoy the power of knowledge and influence encourage less powerful patients who depend on them for care to forgo their rights, such as to confidentiality, for protection of the more powerful actor's interests.

References:

FIGO Framework for Gynecologic and Obstetrical care.

FIGO Guidelines Regarding Informed Consent

B.M.Dickens, R.J. Cook. Conflict of interest: legal and ethical aspects International J, Gynecol. Obstet. 2006; 92(2): 192-7.

Involuntary Female Sterilisation

Case:

Mrs Magoë, aged 34, has four children and is pregnant again. She and her husband are very poor, and decide to begin to use efficient, government-funded contraception after delivery. She attends a government-run hospital to see Dr Deen, seeking advice on an appropriate contraceptive method. There is a concern in the country about the increasing population growth, and all hospitals are under pressure from the government to increase contraceptive use and to decrease fertility. The government has recently adopted a national regulation stating that any woman with three or more children can continue to have free hospital delivery only if she agrees to be sterilized after delivery. Furthermore, disciplinary action will be taken against any non-compliant hospital physician who provides delivery without charge for a fourth or subsequent child..

Questions:

Would it be ethical for Dr. Deen to pressure Mrs. Magoë to agree to sterilisation, even though she is reluctant ?

Is Dr. Deen ethically bound to deny Mrs.Magoë unpaid hospital delivery unless she accepts sterilisation, knowing that she cannot afford to pay for hospital services and that medically unattended delivery of her fifth child would be hazardous ?

Would it be ethical for Dr. Deen to deny Mrs.Magoë contraceptive care, saying that sterilisation is her only choice?

Would it be ethical for Dr. Deen to supply a long-acting contraceptive means, and certify that Mrs.Magoë has been sterilised (by a method with the highest failure rate)?

Would a vasectomy for Mr.Magoë, with the possibility of reversal, ethically satisfy Dr. Deen's obligation to reduce the chance of Mrs. Magoë having another child?

Assessment:

Female sterilisation is a safe, simple and very effective surgical procedure. It can usually be done under local anaesthesia and light sedation. Post-partum sterilisation is done by minilaparotomy (a small abdominal incision).

Because female sterilisation should be considered permanent, the decision made by the woman must be based on voluntary informed choice and should not be made under stress or pressure. Other methods of contraception should be introduced and offered, to allow women to make free choices. The intra-uterine device is a good alternative for women who want long-term contraception, and long-acting subcutaneously implanted contraceptive rods are also available.

Ethical Analysis:

Respect for Persons:

The aim of family planning programs is to enable couples and individuals autonomously and responsibly to decide the number and spacing of their children, to have the information and means to do so, and to ensure informed choices. This aim includes making available a full range of safe and effective methods, including female and male sterilisation. The International Federation of Gynecology and Obstetrics (FIGO) Committee for the Ethical Aspects of Human Reproduction and Women's Health, in outlining ethical considerations in sterilisation, stated in 2000 that "No incentives should be given or coercion applied to promote or discourage any particular decision regarding sterilisation. In particular, withholding other medical care by linking it to sterilisation is unacceptable".

The principle of respect for persons includes due protection of vulnerable individuals. Mrs. Magoe is vulnerable to involuntary sterilisation or the hazards of delivering her fifth child without medical care, due to her poverty. Dr. Deen is not accountable for this, but the government policy exploits her financial inability to pay hospital costs of childbirth to induce her to accept sterilisation against her choice. Dr. Deen may ask the disciplinary authorities for permission to provide Mrs. Magoe with safe, unpaid delivery of this child, and appropriate contraception. The FIGO 2000 statement concludes that "At a public policy level, the medical profession has a duty to be a voice of reason and compassion, pointing out when legislative and regulatory measures interfere with...appropriate medical care".

Benefit and Avoidance of Harm :

It is legitimate for a government to be concerned about rapid population growth and its harmful impact in impairing socio-economic development. Promoting awareness of and provision of family planning services, including education and information on voluntary sterilisation for men and women, are beneficial social measures. Furthermore, a woman's repeated pregnancy, especially at short birth-intervals, presents increasing risk for the mother and her future children's health. However, a government policy that operates to deny poor women necessary medical care in childbirth is harmful to both mothers and their children. It is also injurious to the dignity of poor families that, unlike families of greater means, their medical providers are required to offer them desirable health services only on condition of their acceptance of an oppressive option.

Justice:

When there are limited state resources, and free delivery of maternity care is linked to acceptance of another measure like sterilisation, the policy may unjustly deny care to women of relatively high parity, compelling them to forgo care or seek services, including abortion, from unqualified providers. All pregnant women should receive similarly safe care in pregnancy. The policy is unjust in addition for its discriminatory focus on sterilisation of women having children, and not addressing male procedures.

Dr Deen should be able to provide Mr. and Mrs Magoe, equally with other patients, with enough information of contraceptive methods appropriate to their needs,

including sterilisation and reversible forms of family planning which are comparably effective. Mr. and Mrs Magoë should be properly counselled concerning the risks and benefits of sterilisation and of its alternatives, and exercise choice unrestrained by their limited funds. Human rights principles protect individuals against medical procedures to which they do not freely consent, and the concept of reproductive health includes “the capability to reproduce and the freedom to decide if, when and how often to do so”. Dr Deen can invoke the physician’s ethical duty of equal respect for all patients in order not to require pregnant women unable to pay for indicated hospital delivery services to agree in advance to sterilisation as a condition of receiving free care, and speak out against the injustice of a policy that compromises the voluntary treatment of poor women.

References

FIGO statement on Female Contraceptive Sterilisation.

UN Department of Public Information, Platform for Action and Beijing Declaration, Fourth World Conference on Women, Beijing, China, 1995. New York:UN, 1995, paragraph 94.

UNESCO Chair in Bioethics Reproductive Health Case Studies with Ethical Commentary

C. Zampas, A. Lamackova Forced and Coerced Sterilization of Women in Europe. *Int.J. Gynecol. Obstet* 2011; 114 (2): 163-6.

Multiple Pregnancy

Case:

Reba, aged 40, has been childless throughout her 16 years of marriage. She and her husband inform Dr. Paulin, who is a specialist at an infertility clinic, that they want to have a baby before Reba is 42. They request hormonal stimulation of ovulation either to enhance natural reproduction or for in vitro fertilization (IVF), perhaps with intracytoplasmic sperm injection (ICSI), in either case to maximize the chance of a singleton pregnancy. Dr. Paulin is aware that hormonal stimulation of ovulation, and multiple embryo transfer in IVF, may result in multiple pregnancy, although transfer to her uterus of more than a single embryo may be indicated for Reba due to her advanced maternal age.

Questions:

Can Dr. Paulin ethically recommend hormonal stimulation for natural fertilization knowing that dosage levels can achieve effects from failure of fertilization up to high multiple pregnancy?

Can Dr. Paulin ethically advise hormonal stimulation for IVF, intending that any surplus embryos, which are likely to remain, would be used for transfer to others, research or teaching, provided that Reba consents?

Can Dr. Paulin ethically require fetal reduction if Reba has a triplet or higher multiple pregnancy?

Can Dr. Paulin ethically comply with Reba's request to reduce a twin to a singleton pregnancy?

Assessment:

Hormonal stimulation for natural reproduction risks unpredictable levels of multiple pregnancy, whereas in IVF, doctors can control the number of embryos transferred. For women aged 35 and over, transfer of more than a single embryo is often advised, to increase the chance of pregnancy and childbirth. However, up to the age of 40, it has been shown that repeated single embryo transfer, after freeze/thawing if necessary, is as efficient as multiple embryo transfer. In the UK, just under a quarter of live births from IVF are of twins, down from nearly a third in 2008, reflecting a policy favouring single embryo transfer (SET). Women seeking medically assisted reproduction (MAR) tend to be of relatively advanced age, however, which is often considered to justify stronger means to stimulate ovulation, and uterine transfer of more than single embryos, both of which increase the possibility of multiple pregnancy.

Ethical Analysis:

Respect of Persons:

Hormonal stimulation of Reba increases her prospects of achieving a desired pregnancy, whether by natural fertilization or IVF. She is vulnerable, however, to a clinic's proposal to treat her only on the condition that she accepts to continue a twin pregnancy, since, in the event of multiple pregnancy, the clinic will not undertake fetal reduction to singleton birth as a matter of principle and economic use of limited resources. There are ethical concerns, however, about requiring or conditioning a woman to have more children than she really wants. This would compromise her autonomy, and leave the risk of jeopardising her health and that of the fetuses *in utero* and the children following birth.

Benefit and Avoidance of Harm:

Facilitating a patient to overcome infertility and have the child she wants is beneficial, but the risk of multiple pregnancy, even of no more than twins, is increasingly regarded as a complication or dysfunction of many forms of MAR. Hormonal stimulation itself creates a risk of ovarian hyperstimulation syndrome (OHSS), which has proven fatal, although in modern times this risk is usually well controlled. The main burden of multiple pregnancy is to fetuses *in utero*, children at (often premature) birth, and prenatally and post-partum to the women who bear them. It was observed in the UK in 2007 that the stillbirth rate for multiple pregnancies was four times higher than for singletons, and that multiple gestations are a substantial contributor to overall perinatal mortality rates. Beyond individual costs are the social costs to hospital and health care systems of coping with the neurodevelopmental impairments and respiratory and gastrointestinal complications to which preterm babies are particularly prone.

Justice:

The effect of a patient accepting the risks to herself and her twin or more newborn children of multiple birth may be to burden a public health care and educational system with the costs of prolonged responsibility for their well-being. This raises ethical questions of social justice, and has inspired some health care systems in developed countries to subsidize MAR in order to promote SET, and perhaps multifetal reduction. Some may see reduction as abortion of the implanted embryos or fetuses sacrificed *in utero*, but the FIGO guidelines observe that reduction of greater than a twin pregnancy "is not medically considered as terminating that pregnancy but rather as a procedure to secure its best outcome." If ultrasound or other means show a fetus *in utero* to be severely impaired, its selective termination raises ethical issues of implied devaluation of handicapped members of the community. If all fetuses are of equal potential, the selection of one or more for termination raises ethical concerns of achieving equality in random targeting.

References:

FIGO Ethical Guidelines on Multiple Pregnancy.

FIGO statement on Fertility Centres and Who They Should Treat.

B.M.Dickens, R.J. Cook. Multiple Pregnancy: Legal and Ethical Issues. *Int. J. Gynecol Obstet* 2008; 103(3): 270-274.

Obstetric Fistula

Case

Shala, aged 16, married for the last two years, lives in a remote underserved area. She had her first pregnancy at the age of 15, and no antenatal care was available to her. Labour was under the care of a traditional birth attendant, with no facilities or support for emergency obstetric care. After three days in prolonged, obstructed labour, she delivered a stillborn baby, and observed urine leaking three days later. The traditional birth attendant could give no advice on that, and the nearest hospital capable of providing treatment and support is 300 kilometres away, with no facilities for easy transportation. Shala's family and her husband's are too poor to afford travel expenses. She became depressed, and her husband left her, as well as her friends. She is required to live in isolation outside her village, and not to join in preparation of food for others.

Twelve months ago, a small health clinic was established 5 kilometres from the village, staffed by two nurses and a midwife. Dr. Perri, a gynecologist at the distant hospital, spends 10 days at the clinic every 4 months. Shala's father took her to the clinic, where Dr. Perri examined her, and found that she has a vesicovaginal fistula (VVF) and a rectovaginal fistula (RVF)

Questions:

Is Dr. Perri ethically bound to assist Shala to cope with her condition ?

Should Dr. Perri ethically pressure the hospital to offer fistula repair services for Shala ?

Should Dr. Perri seek to equip the clinic to undertake fistula repair ?

Does Dr. Perri have wider ethical responsibilities to potential patients in Shala's circumstances?

Assessment:

The case of Shala illustrates a number of issues related to injustices in the provision of essential healthcare, including concerns related to early marriage, and the lack of sensitivity in the medical care system to the provision of care needed by impoverished individuals, families and communities.

Early marriage is a harmful traditional practice prevalent in developing countries, and Shala is a victim of this social injustice, exposing her to early pregnancy and premature childbirth, which is liable to result in maternal death or, among other disorders, affliction by the major disability of VVF/RVF.

Shala's tragedy is being faced by thousands of young women in developing countries, and highlights the social injustice that has to be addressed by communities and their governments. Medical care in general, and reproductive health care in particular, raise concerns that governments need to address as a priority. Access to essential health services is a basic human right, and should be central to the mission of governments committed to the welfare of the populations they claim to serve.

Ethical Analysis:

Respect for Persons:

Shala's autonomy would clearly be served by Dr. Perri affording her the means to access fistula repair, but an earlier issue of her autonomy concerns her marriage. In some traditional cultures, girls are married at an early age, to relieve parents of providing for them, or to relieve their fear that their unmarried adolescent daughters will become sexually curious, then active, and then pregnant, or that unscrupulous men will sexually abuse them, in either case resulting in family dishonour. Dr. Perri alone can probably do little to affect this directly, but can give voice and support to laws that protect adolescents' human rights to independence appropriate to their maturity, including enforcement of minimum age of marriage laws, and to everyone's human right to marry only voluntarily.

More immediately, recognizing that fistula repair may not be feasible in Shala's current circumstances, Dr. Perri has to address her incontinence of urine and vaginal feces, and associated liability to infection. This may require mobilization of the clinic's resources, and gathering family and community resources, to maintain her hygiene, and morale.

Benefit and Avoidance of Harm:

Dr. Perri travels between the hospital, 300 kilometres away, and the local clinic every 4 months. The doctor should therefore enquire whether Shala and perhaps a family member could be company on a journey, to reach the hospital's fistula repair service. In addition, Dr. Perri should see whether the local clinic's midwife or nurse might be trained to undertake diagnosis, management and repair of at least the more simple fistulas.

Dr. Perri's ethical duties of promoting benefits of members of the community dependent on the local clinic and minimizing harm they are liable to suffer includes informing and educating them about the hazards of adolescent girls' early marriage and premature motherhood, perhaps illustrated by the case of Shala, with which they will be familiar. Instruction should address not only health hazards, but also the devastating effects on families, both of a married couple and of each partner.

Justice:

The transcending injustice leading to the tragedy affecting Shala and innumerable other young women who are, or are at risk of becoming, similarly situated, is their lack of prenatal care and skilled attendance at birth, including means of timely referral in case of emergency such as unduly prolonged labour. Many governments explain their failures to allocate resources to health services by poverty, but many national governments conceive of defence of their populations primarily in military terms, such as in the manufacture or purchase of weapons and other armaments. If they could be inspired or required to divide budgets so that expenditure per capita of population on health defence equalled that on military defence, health protection of their populations might be considerably improved. As a health care professional in gynecology, Dr. Perri might be ethically expected to urge with colleagues and actively promote adequate funding of prenatal and childbirth services, to allow the Shalas in the communities the doctors serve safely to deliver and raise healthy children.

References:

FIGO Ethical Guidelines on Obstetric Fistula.

FIGO statement on The Role of OB/GYNs as Advocates for Women's Health.

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A.T.Lassey Simple Fistulas: Diagnosis and Management in Low-Resource settings-A Descriptive Report *Int.J. Gynecol. Obstet.* 2007; 99, Suppl.1 :s47-s50.

Refusal of Caesarean Section

Case:

Regina, aged 28, a married woman living with her husband and four-year-old daughter in modest circumstances, is in hospital experiencing uterine contractions near the end of her uneventful second pregnancy. Dr. Obstet, interpreting readings of the fetal heart rate monitor, fears that her fetus, which has been shown to be male, may lack adequate oxygen supply, and advises Regina to have a caesarean-section delivery. Regina declines, saying she wants natural delivery. Dr. Obstet describes the risk of fetal brain damage, but Regina says she will not consent to surgical delivery, unless her or the fetus's life is in danger. When Regina's husband asks about her progress, Dr. Obstet explains the position. The husband says he will approve C-section delivery, paying the extra cost with all of the family's savings, so that his son is not brain damaged.

Questions:

Is Dr. Obstet ethically bound by Regina's refusal?

Can Dr. Obstet ethically act on the husband's approval?

Can Dr. Obstet ethically risk the family's savings on surgery that may not prevent fetal brain damage?

Can the husband claim to speak on behalf of the fetus ?

Assessment:

Dr. George Macones, who headed development of the American College of Obstetricians and Gynecologists (ACOG) July 2009 Practice Bulletin on Electronic Fetal Monitoring (EFM), has noted that EFM has not reduced rates of perinatal mortality or cerebral palsy, although use has reduced risk of neonatal seizures. During labour, EFM has little effect in reducing rates of cerebral palsy, because 70 per cent of cases occur before labour begins and only 4 per cent are attributed solely to events during labour and delivery.

When EFM indicates risk to the fetus, interventions are possible, such as increasing the woman's oxygen supply and/or inducing vaginal delivery possibly with use of forceps, without resort to C-section delivery. An effect of availability of EFM is a significant increase in caesarean deliveries. The ACOG Practice Bulletin was published in July 2009 to reduce the rate of C-section deliveries that are unnecessary. C-section delivery is usually safe, but this surgical procedure is far more costly than natural delivery, and does present some risks to the mother and/or baby. It may also raise complications in the woman's subsequent pregnancy.

Ethical Analysis

Respect for Persons:

Respect for Regina's self-determination or autonomy should make her refusal conclusive, but she will accept surgical delivery if there is danger to life. Dr. Obstet's duty of truth-telling precludes claiming that Regina's life is at risk. Risk to the life of the fetus/child is a matter of medical assessment, to be made in good faith and not instrumentally in order to justify C-section delivery. The fetus may be vulnerable and so merit protection, but

Regina is vulnerable to being pressured or manipulated into C-section delivery that she disfavours, to the risks to her and her fetus of surgical delivery, and to Dr. Obstet's superior knowledge. This justifies her protection against subjection to unwanted surgery, which may be futile if the fetus is already damaged, and unnecessary.

The husband's preferences warrant respect, but he cannot legally authorize surgery his wife refuses, unless perhaps her life is at immediate risk. Similarly, he is not necessarily more ethically entitled to claim to represent the interest of the fetus than is Regina, although prevention of avoidable severe injury to the fetus and child on birth is an important value.

Benefit and Avoidance of Harm:

C-section delivery may benefit the child on its birth, but also poses risks to the fetus, and to the mother in this case or in her later pregnancy. The rule that any later pregnancy will require C-section delivery is no longer as firm as it once was, but account must be taken of this in Regina's circumstances, in assessing the benefit-to-risk ratio. C-section delivery in experienced hands is usually considered a safe procedure, but may financially burden a family that must meet costs from its own resources, or deplete health care resources on which other patients depend.

Justice:

Dr. Obstet should consider whether a motivation to favour C-section delivery would protect the doctor's reputation for care at the cost of burdening Regina and/or her fetus with the risks, and her family with the expenses, of perhaps futile or unnecessary surgery. That is, Dr. Obstet will have to resolve any ethical conflict of interest. The family has limited means, which may be applied for the daughter's benefit if they are not exhausted by the costs of a C-section delivery of a son. The risk of family impoverishment and deprivation may be a natural burden of membership of a family in which meeting the needs of one may be at the cost of others. If Regina's husband participates in a culture of son-preference, so that he would sacrifice family resources to favour a son when he would not to favour a daughter, his sex-discriminatory preference for C-section delivery may appear less justified.

References

FIGO. Ethical Framework for Gynecologic and Obstetric Care.

FIGO. Ethical Guidelines regarding Interventions for Fetal Well-Being.

FIGO. Ethical Aspects concerning Neonatal Screening.

ACOG. Practice Bulletin No. 106. Intrapartum Fetal Heart Rate Monitoring. *Obstet Gynecol* 2009; 114(1): 192-202.

Refusal of Treatment

Case:

Thandi, a 19-year-old woman who is unmarried but has a partner, visits a government antenatal clinic, where it is confirmed that she is pregnant. Three out of every ten women who attend public antenatal clinics in the region are HIV-positive. Due to the high prevalence of HIV amongst pregnant women, all women who attend such clinics are routinely tested for HIV and Thandi was tested for the same without her knowledge. On her next visit to the clinic for her follow-up appointment, the attending doctor, Dr. Zaku, counseled her before disclosing her HIV-status to her. Dr Zaku explains to her that she needs to be treated with ARVs for her own sake and to prevent the risk of her transmitting the infection to her unborn child during natural childbirth. Thandi refuses treatment because in her society HIV-positive women are ostracized. She requests that her HIV status be kept confidential.

Questions:

Should Dr Zaku ethically respect Thandi's wishes not to be treated?

Can Dr. Zaku ethically require that Thandi receive prevention of mother-to-child transmission (PMTCT) treatment against her wishes?

Can Dr. Zaku ethically give priority to the interests of the fetus/child to be born over those of Thandi?

Can Dr. Zaku ethically suggest to Thandi that she should terminate the pregnancy?
Should Dr Zaku ethically heed Thandi's request for confidentiality?

Assessment

Many people are unaware that they are infected with HIV. Less than 1% of the sexually active urban population in Africa has been tested, and this proportion is even lower in rural populations. Furthermore, only 0.5% of pregnant women attending urban health facilities are counselled, tested or receive their test results. This proportion is even lower in rural health facilities. Based on its sample of 32,861 women attending 1,447 antenatal clinics across all nine provinces, the South African Department of Health Study estimated that 29.4% of pregnant women (aged 15-49) were living with HIV in 2009.

Ethical Analysis:

Respect for persons

Thandi's autonomy regarding refusal of treatment and confidentiality is sound in light of the impending threat of being ostracized by her family, community and society in general. However, Dr. Zaku has the unenviable task of trying to convince her to take the treatment due to the fact that an estimated 40,000 children in South Africa are infected with HIV each year, reflecting poor prevention of mother-to-child transmission (PMTCT). Moreover, AIDS is one of the main contributors to South Africa's infant

mortality rate, which increased significantly between 1990 (44 deaths per 1000 infants) and 2008 (48 per 1000), when all regions of the world saw decreases.

Benefit and Avoidance of Harm:

With protection of confidentiality, ARV treatment would be beneficial not only to the fetus/child, but to Thandi as well. The level at which someone begins antiretroviral therapy has a great impact on their chances of responding well to treatment. It needs to be noted that for antiretroviral therapy to work, patients must adhere to a daily regimen of ARVs for life. Interrupting treatment can result in HIV becoming drug resistant, making first-line therapy no longer effective. With high local HIV prevalence and universal precautions, all women are treated as HIV positive, so clinic staff do not need to know Thandi's HIV status, thus avoiding the harm of disclosure. However, since Thandi has a partner, risk of harm to him necessitates Dr. Zaku to advise Thandi that her partner needs to know of her status and the urgency of his being tested for HIV so that precautionary measures may be taken by her partner in the interim while awaiting his HIV test results.

Justice:

HIV test without Thandi knowing raises ethical issue of whether HIV testing should be routine, and so not specifically mentioned, or whether HIV-exceptionalism requires patients to be asked before HIV testing is undertaken? It is to be conceded that HIV is unlike other infections and ethically different because of the multifaceted impact it has on the family, society and the country at large. With an estimated 5.6 million people who were living with HIV and AIDS in South Africa in 2009, more than in any other country, justifies implementation of HIV counselling and testing (HCT) which aims to offset the problem of late or no diagnosis. Routine HIV testing and counselling is vitally important in order to make treatment accessible to infected patients. Knowledge of one's positive status can lead to protecting other people from being infected.

References

FIGO Guidelines Regarding Informed Consent.

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<http://www.doh.gov.za/docs/misc/stratplan-f.htm>.

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Reinfibulation

Case:

When Lina was eleven years old, her mother submitted her to genital cutting by the most severe form, infibulation. Now aged 22 and married, she has just safely delivered her first child. She has asked the doctor who has attended her throughout her pregnancy and delivery, Dr. Ashin, to put her back the way she was by reinfibulation.

Questions:

Can Dr. Ashin ethically simply comply with Lina's request?

Should Dr. Ashin inform Lina that it is considered unethical for a doctor to undertake infibulation, and refuse?

What ethical factors should Dr. Ashin consider in deciding on Lina's request?

Does Dr. Ashin have any ethical duties to Lina's community?

Assessment:

The female genital cutting that precedes infibulation is professionally condemned among physicians, and increasingly considered a human rights violation, particularly when undertaken on young girls incapable of making their own decisions to consent to the procedure. However, legal systems may consider adult and mature adolescent women capable to agree to limited forms of genital surgery, whether for ritualistic or cosmetic purposes. However wrongful initial infibulations may have been, reinfibulation does not involve significant cutting, but resuturing.

A principled professional objection to postnatal reinfibulation is that it may appear to endorse the practice of infibulation, and afford it a degree of medical professional legitimacy and acceptability. That is, medicalization may make female genital cutting appear tolerable. The FIGO 2006 Statement on Female Genital Cutting condemns all forms, but requires that women who have been subjected to any such procedure be treated with sympathy and respect. It further observes that, depending on local laws, "properly informed women who...following childbirth, independently request resuturing should not be denied treatment." It is recommended, however, that practitioners explain the benefits of unsuturing, and advise against reinfibulation.

Ethical Analysis:

Respect for Persons:

Dr. Ashin's agreement to Lina's request would serve Lina's autonomy, provided that her request is made independently and not pressured by her husband or, for instance, family members. If it were to be seen as medically supporting infibulation, however, compliance with her request might aggravate the vulnerability of young girls in Lina's community to be subjected to dangerous invasive genital cutting. Dr. Ashin accordingly has to decide whether Lina's request can be granted while she, her family and community at the same time can be given to understand that female genital cutting is often a harmful procedure, not required by any religion, and professionally considered unethical.

Benefit and Avoidance of Harm :

The contrast between performing a beneficial act and inadvertently contributing to harm, which in this case refers to doing what Lina requests and affirming female genital cutting as a legitimate medical procedure, pitches the microethical values of an individual against macroethical values that serve a community. For Lina to resume her familiar sense of physical identity and integrity after childbirth, as she wishes, would be beneficial for her in a direct way, whereas the harm to her community of medicalizing female genital cutting by reinfibulation would be indirect and speculative. Lina may be advised against resuturing, for her own advantage and for the social or communal benefit of opposing female genital cutting as a practice in her region. If she still requires the procedure, however, Dr. Ashin must weigh the competing benefits and harms, and their relative likelihood and proximity, in deciding whether to grant Lina's request, or leave her to other options she may have.

Justice:

Dr. Ashin must determine whether reinfibulation is like original infibulation, or different in some ethically relevant way. If the former, Dr. Ashin should ethically decline to undertake it, but if the latter, the procedure will not necessarily be as objectionable, and may be undertaken, with due caution to resist legitimation of the prior genital intervention. Laws in some countries differentiate between genital procedures on young girls incapable of consent, and procedures that adult women may request for cosmetic or comparable purposes. Initial cutting presents risks, for instance of trauma and infection, not present in medically undertaken reinfibulation, which may involve no cutting or minor tissue treatment. As against those contrasting distinctions, however, reinfibulation may be comparable to infibulation in being professionally condemned as an unnecessary medical procedure that is demeaning and harmful to women in general.

References:

FIGO statement on Female Genital Cutting.

FIGO statement on The Role of OB/GYNs as Advocates for Women's Health.

G.I.Serour. The Issue of Reinfibulation. *Int. J. Gynecol Obstet* 2010; 109(2) :93-6.

Social Sex Selection

Case:

Mrs Bee, a 36 year old mother of two daughters aged 10 and 6, lives in a remote mountain area with her sick 40 year old husband. Mr and Mrs Bee strongly feel they need a son to support their family, especially in their old age. Mrs Bee comes to see Dr Redil, explaining that she thinks she is now about 12 weeks pregnant. State law prohibits prenatal determination of sex except for a sex-linked genetic disorder. Mrs Bee asks Dr Redil whether she can have a test to determine if the fetus is male or female. Mrs Bee says that she would be willing to continue the pregnancy only if she would have a son. Because of her medical history, state law would allow Mrs.Bee to terminate her pregnancy.

Questions:

Should this case be approached ethically as concerning sex-based abortion, or sex-based continuation of pregnancy?

Is the ethical duty of Dr. Redil only to Mrs. Bee, or may societal interests, such as a community sex-ratio imbalance, be taken into account?

Is Mrs. Bee's request ethically discriminatory?

Is it of ethical relevance that, if Mrs.Bee is denied prenatal sex diagnosis, she will abort the pregnancy?

Assessment:

It is possible to select sex of an embryo or fetus for non-medical reasons by the same techniques that are usually performed for prevention of sex-linked disabilities, including amniocentesis, chorionic villous sampling and ultrasound diagnosis. The techniques for sex selection have expanded in recent years, such as sperm separation, PGD, embryonic cell biopsy and Y fetal DNA detection in maternal blood by PCR. These tests are important in medical practice in providing valuable information about genetic abnormalities of the fetus. However, prenatal tests that were developed to detect abnormalities in the fetus have been (mis)used simply for fetal sex selection and sex-based abortion, especially in countries with a culture of son-preference.

Ethical Analysis

Respect for Persons:

Respect for the autonomy of Mrs.Bee would be served by Dr.Redil conducting a form of prenatal diagnosis. However, her autonomy may be affected by the legal restriction of prenatal diagnosis of fetal sex, reflecting the common presumption that such diagnosis is intended to result in abortion of female fetuses. Similarly, the FIGO 2005 statement on sex selection for non-medical purposes allows prenatal sex diagnosis "only for medical indications or purposes that do not contribute to social discrimination on the basis of sex

or gender”. This raises the ethical issue of whether, in feeling they can accommodate the birth only of a son, Mrs. Bee and her husband are perpetuating social sex discrimination, or whether they are victims of it. This may be because their experience creates their belief that, when old and dependent, they cannot be supported by their grown-up daughters who, on marriage, are likely to leave the parents’ home.

Benefit and Avoidance of Harm:

Son-preference is deeply seated in many cultures, especially in China and India. Figures for instance from China and South Korea on sex ratios at birth show sex-selected abortion skewing the population towards a dysfunctional preponderance of males. The FIGO 2005 statement on sex selection for non-medical purposes is designed to eliminate the harm of discrimination. It opens by observing that “The [Ethics] Committee deplors all forms of discrimination against women and the use of any medical techniques in any way that would exacerbate discrimination against either sex. Sex selection is of particular ethical concern when it is driven by value differences ascribed to each sex or that arise from pervasive gender stereotypes.”

Denial of prenatal sex diagnosis to Mrs.Bee, however, may also cause harm. Not knowing the fetal sex, she will abort a pregnancy that she would continue if the fetus was shown to be male. This raises the ethical concern of whether it is preferable that she should have a perhaps unnecessary abortion, or risk perpetuation of sex-discrimination for the benefit of continuing gestation of a fetus she knows is male.

Dr.Redil faces the ethical dilemma of serving the wider social interest opposing sex-based abortion and harming Mrs.Bee’s intentions to deliver a son, or affording her the benefit of the chance to deliver a son but complying with a sex-discriminatory culture harmful to women.

Justice:

The promotion of women’s rights equal to those of men offers the promise to counteract social sex-selection against females pervasive in some areas of the world . All health professionals and their societies are under the obligation to advocate and promote strategies that will encourage and facilitate the achievement of gender and sex equality. However, sex-selection against females may be only a symptom, not the cause, of discrimination against women. As an advocate for women’s improved status in society, Dr Redil may demonstrate that laws or policies to prohibit sex-based abortion do not address the roots of the problem, and fail to remedy the injustice of pervasive discrimination against girl children and women.

The ethical problem Dr.Redil must address in the case of Mrs.Bee is whether to resolve it at the clinical (microethical) level, or at a societal (macroethical) level. The former might allow prenatal sex diagnosis under the law, since the law’s purpose is to prevent sex-based abortion, not sex-based continuation of pregnancy. Any uncertainty in the scope of prohibitive law is to be decided in favour of individuals’ freedom. The latter approach, denying prenatal sex diagnosis, would discount the patient’s interests in favour of a wider goal of equality of the sexes, and social justice.

References

FIGO statement on Sex Selection for Non-Medical Purposes

FIGO statement on The Role of Obs/Gyns as Advocates for Women's Health.

UNESCO Chair in Bioethics Reproductive Health Case Studies with Ethical Commentary

B.M. Dickens, G.I. Serour, R.J. Cook, R-Z. Qiu. Sex Selection: Treating Different Cases Differently. *Int. J. Gynecol. Obstet* 2005; 90 (2): 171-7.

Surrogacy

Case:

Mrs Abced, 36 years old, has menorrhagia with a regular cycle, and is extremely anaemic. Mother of a 4 years old child, she is also trying to conceive a second child.

Ultrasound assessment of her uterus shows multiple fibroids distorting the uterine cavity. There are two separate indications for myomectomy, the size of her largest fibroid (7 cm), and the distortion by other smaller intramural fibroids. After consultation with her gynaecologist, Dr. Neutro, she agrees to surgery, aware that there is a chance of hysterectomy. She feels her quality of life is low, and her lack of energy due to anaemia is not improved by the usual medication available. She has already thought of surrogacy as an alternative to natural conception. She asks the surgeon to ensure conservation of her ovaries above all other priorities.

The surgeon is unable to conserve the uterus, but otherwise she recovers fully. Her ovarian function is still satisfactory, and her husband's semen analysis is normal. Six months later, she and her husband ask Dr. Neutro to help their search for a surrogate to gestate an embryo she and her husband intend to create by in vitro fertilization (IVF).

Questions:

Can Dr. Neutro ethically ask another of the doctor's own patients to serve as a surrogate mother for Mrs. and Mr. Abced's child ?

Can Dr. Neutro ethically ask a woman with young children of her own to serve as a surrogate mother ?

Can Dr. Neutro ethically attend to Mrs. Abced's hormonal stimulation for IVF and also manage the surrogate during her pregnancy?

Can Dr. Neutro ethically agree to Mr. Abced's unmarried, childless sister serving as the surrogate mother ?

Assessment:

Surrogate motherhood has become accepted as a legitimate reproductive option in many countries, particularly for women who are medically incapable of gestation, but it remains widely subject to legal regulation, for example, of payment. Many countries permit reimbursement of surrogates' out-of-pocket expenses, for instance, but prohibit or tightly regulate reward or gratitude payments. Policies differ, and may conflict, on who may be a surrogate. Some laws provide that only women who have the experience of pregnancy and childbirth can give informed consent to serve, while in contrast others prohibit women with young children from serving, claiming that young children's care should not be disrupted by their mothers' surrogate pregnancies, and that children might feel insecure to realise that their mothers would give away their babies.

This case involves "full" surrogacy, meaning that the surrogate mother would be genetically unrelated to the child she delivers. In contrast would be "partial" surrogacy, in which the surrogate would gestate her own egg, fertilized artificially by Mr. Abced's or

another man's sperm, without IVF. The difference can affect legal recognition of who are the "real" parents of a newborn child.

Ethical Analysis:

Respect for Persons:

Although legally restricted in some European countries, surrogacy enhances a reproductively impaired couple's autonomy by giving them the choice to have a child genetically related to both or at least one of them. The surrogate mother's autonomy may be severely prejudiced, however, and her vulnerability exploited, if she comes under family or comparable pressure to serve. She may be similarly vulnerable if poverty tempts her to agree to serve under the promise of lawful or unlawful payment. However, compensation for pregnancy-related expenses and loss of actual income is generally considered ethically acceptable, and perhaps necessary. Some women take pleasure and pride as surrogate mothers in giving other couples the gifts of their babies' lives, but they should not ethically be required to subsidize their gesture.

Pregnant women generally accept limits to their autonomy for the sake of their fetuses, such as regarding their diets and alcohol and/or tobacco use. They may also accept antenatal screening, which may lead to hard decisions on detection of fetal anomalies and/or maternal health risks. On these occasions, the autonomy of surrogate mothers and of intended parents may conflict.

Benefit and Avoidance of Harm:

When surrogate motherhood agreements work satisfactorily, receiving parents, surrogate mothers and societies benefit., although to what comparative advantage is difficult to quantify. If relationships among participants should sour, agonizing emotional, and legal, results may follow. However, even in the most favourable of circumstances, pregnancy involves unavoidable risks to mothers' health and very lives. No country has zero maternal mortality. For Mrs.Abcde, there are irreducible minimum risks, perhaps of ovarian hyperstimulation syndrome (OHSS), and of oocyte retrieval for IVF. It is therefore essential that all prospective participants receive disinterested counselling about their individual risks. Potential surrogate mothers should be relatively young, physically healthy, and psychologically able to accept the implications of surrendering the babies they have gestated. Single embryo transfer is advisable, in order to avoid the risks of multiple pregnancy, the most common complication of IVF.

Justice:

There may be a risk of social injustice if practitioners dedicate disproportionate time to surrogacy arrangements, perhaps because of their complexity or income generation, where there is a general lack of adequate routine antenatal care for their local populations. A more particular injustice may arise if poor and/or unemployable women are induced to accept the burdens and risks of surrogate pregnancy for payments, which themselves may be exploitatively low. A comparable challenge to justice might arise if women capable of healthy gestation were to recruit paid surrogates to gestate their children, so that they could avoid stretch marks, inconvenience, or, for instance, career disruption. Laws that unduly complicate recognition of children's legal parentage, when

surrogate motherhood agreements are entered in good faith and work to all participants' satisfaction, require s ethical reform.

References:

FIGO statement on Surrogacy

FIGO statement on Ethical Considerations with Oocyte and Ovarian Cryopreservation in Women.

FIGO statement on Fertility Centres and Who They Should Treat.

FIGO statement on Safe Motherhood

Task Shifting and Maternal Mortality

Case:

Fatoumata is 15 years old. She was married the previous year, and soon became pregnant. Her village is one hundred miles from any urban medical centre. In her community, pregnancy is considered a natural event, with no necessity, or capacity, for a physician's care. The only persons caring for pregnant women and attending delivery in this rural community are the matrons, the traditional birth attendants (TBAs). All pregnant women in Fatoumata's family, and community, have been delivered by matrons. One of her aunts and an elder sister died during delivery. An emergency care facility has now been installed in a nearby village. The health professional in the facility is not a physician, but a male nurse, a health officer, practising after three years of specialised training.

Fatoumata has been in labour for two days, is bleeding from the uterus, and complaining of insufferable pain. The matron perceives no progress in labour, the uterine cervix being only two fingers dilated after two days of regular, painful, uterine contractions, and the head of the baby is still very high in the pelvis.

The matron knows there is now the need for a caesarean section, to prevent the likely death of Fatoumata and her baby from a rupture of her uterus. Her family is too poor to hire an ambulance for her transfer to a city medical centre and to pay for the surgical procedure. Caesarean section for Fatoumata is the only life saving procedure. Only the local health officer is able to attempt a caesarean section.

Questions:

Is it ethically preferable to let the health officer give Fatoumata, and her baby, a chance of survival by performing a caesarean section in this emergency medical setting?

Is it better to let the natural process of birthing give Fatoumata a chance of delivering naturally, without the risk of surgical, and perhaps fatal, complications occurring during caesarean section performed by a non- surgeon?

Assessment:

Every year, an estimated 450,000 women, exceeding one every one and a half minutes, die because they are pregnant. The major cause of maternal death is post- partum haemorrhage, or haemorrhage due to obstructed labour and uterine rupture. Of all maternal deaths, 99 % occur in resource-poor countries where women deliver at home, far away from any emergency obstetrical centre. The main reason for maternal death is poverty. The lack of birth professionals attending home delivery induces a delay in the recognition of obstructed labour (TBAs are not properly trained birth professionals). Poverty explains inability to hire an ambulance to reach a properly equipped urban emergency obstetric centre and to pay for emergency obstetrical care. Neither surgeons nor obstetricians usually practice in isolated rural areas. The rate of emergency caesarean section needed to save maternal lives is considered to be at least 3% of all deliveries. Where there is no doctor, the choice is either to leave the woman in the care of nature, with an extremely high risk of death, or to have a non- physician perform the caesarean section. Indeed several countries in Africa, Mozambique and Ethiopia among others,

have given male nurses or health officers three years' training to perform caesarean sections when necessary. The immediate operative complication rate is no higher than when the procedure is performed by physicians. However, the indications for caesarean section and the long term complications, such as post-surgery vesico-vaginal fistulas, have not yet been properly evaluated.

Ethical Analysis:

Respect for Persons:

Fatoumata has little opportunity for autonomy, since she is vulnerable to her poverty and the deprivations of her location. However, she may choose whether to attempt relief of her pain by treatment performed by the health officer.

“Obstetric professional societies should publicise the tragedy of maternal mortality as a violation of women’s rights...” (FIGO Recommendation on Safe Motherhood).

Benefit and Avoidance of Harm :

If caesarean section performed by a non- physician happened to be worse, and more deleterious, than no surgical procedure at all, then task shifting would be unethical. In fact, where implemented, the benefit of such policy appears to surpass any potential immediate harm inflicted to the pregnant woman. The risk of death from a caesarean section performed by a non-physician is far below the unavoidable risk of death from uterine rupture, and between the two harms, it is preferable to choose the lesser.

Justice:

Maternal death is mostly a consequence of poverty. The burden and hardship of poverty can be partly alleviated by making free all emergency obstetrical care, as advocated by the World Health Organisation. It should include, for any rural community: available free transportation to properly equipped emergency care centres, roads practicable for vehicles, including during the rainy season, in addition to the training of an adequate number of skilled birth professionals, particularly health officers who, in application of task shifting, are able to perform all emergency obstetrical care, especially caesarean sections. Since the level of education of girls and the fertility rate have been shown to significantly influence maternal mortality, distributive justice also implies appropriate investments of governmental and health authorities in the development of schools for girls and of family planning centres.

References:

FIGO statement on Safe Motherhood:

FIGO statement on The Role of the Ob/Gyn as Advocate for Women’s Health.

FIGO statement on Task-Shifting in Obstetric Care.

Termination of Adolescent Pregnancy

Case:

Ella, an adolescent 18 years of age, visited Dr. Abco with a concern about missing her period. Her family is religiously conservative and known to the physician. She had a sexual encounter with a visiting family friend while he lived in the same house. After examining Ella, Dr. Abco informed her that she was ten weeks pregnant. Ella was shocked and pleaded with Dr. Abco to do whatever was necessary to terminate this unwanted pregnancy. The physician was very angry with Ella and admonished her, refusing to help her unless she came back with her parents to discuss any further action. Ella had been brought up in a culture that looked down upon girls engaging in premarital sex. Hence she has had no access to information on normal reproductive function, let alone contraception, either through her family, or through the local school.

Dr. Abco informed her that she would have to undergo a termination of pregnancy if she did not wish to continue the pregnancy. Under local laws, carrying out an abortion is legal and within her right to consent at 18 years of age, but the doctor insisted that Ella get her parents to come to Dr. Abco's office before the procedure could be conducted. Ella's doctor feels conflicted because of knowing the parents and being concerned about potential complications that would make performance of an abortion on their daughter known to them, but also concerned about their being unaware of the circumstances that allowed a visitor to engage in sex with their daughter.

Questions:

Was Dr. Abco's behaviour towards Ella ethically right?

Does the doctor have an ethical obligation to disclose Ella's request to her parents?

Does the doctor have to seek consent for abortion from Ella's parents even though it is legal to perform an abortion without parental consent after the patient is 18 years old in that country?

Should Dr. Abco perform a safe abortion for Ella rather than leave her to go to an unskilled provider, which could endanger her life, fertility or health?

Assessment

Doctors' primary ethical duties are owed to their patients, and they discharge such duties by addressing not only patients' medical conditions but also their health conditions, understood by the World Health Organization to include their "physical, mental and social well-being." Accordingly, patients' family and social circumstances have to be taken into account. Unmarried adolescents' pregnancies will be sources of severe prejudice to them in many family and social settings, denying them for instance future opportunities of education, employment, and marriage, and perhaps of rearing the children they deliver. Where lawful, termination of pregnancy by medically conducted or regulated means may best serve the interests of unmarried adolescents who give their free and adequately informed consent.

Ethical Analysis:

Respect of persons:

Since Ella has requested an abortion that Dr. Abco is lawfully entitled to undertake, the doctor may comply with her request or refer her to another doctor able and willing to undertake the procedure. Dr. Abco should question Ella about whether her parents should be informed, the likelihood of them discovering it if they are not informed, and whether it is feasible for her to pursue her goals in life if she chooses to continue the pregnancy. Compliance with her decision should not be made conditional on Ella informing her parents of her pregnancy, although they may be informed that she requires a gynecological procedure. Ella's autonomy entitles her to control not only any healthcare procedure she undergoes, but also who may receive information that it would violate her confidentiality to disclose without her consent.

Benefit and Avoidance of Harm:

By complying with Ella's adequately informed decisions on abortion and confidentiality, Dr. Abco is acting beneficially. Abortion carries a medically lower risk of complications and death than carrying a pregnancy to term, particularly for young women. Performance of abortion by appropriate means related to the stage of gestation, in a well-maintained clinical setting, will minimize risks to the patient, and save her from an unskilled intervention, including the risks of self-induced abortion. Potential harms of unskilled intervention include hemorrhage, infection, infertility, and death.

Dr. Abco should not be judgmental or condemnatory, but should provide Ella with contraceptive advice following termination of pregnancy, and guidance on means to resist unwanted sexual advances, including by involvement of her parents. Dr. Abco should also be attentive to Ella being depressed due to her unwanted pregnancy, conflict with her religious or spiritual values, and the implications for her of the circumstances in which she finds herself.

Justice:

Dr. Abco affords Ella her rights by providing necessary counselling, advising her of choices lawfully available to her, and by facilitating the outcome she favours. At a wider level, Dr. Abco may advocate for adolescents' access to reproductive and sexual health care education and means. The doctor may also urge parents to be aware of their adolescent children's growing sexuality and liability to sexual curiosity, and their need for guidance, without parents over-protectively denying them opportunities for healthy growth and experience of appropriate social interactions.

References:

FIGO statement on Adolescent and Youth Reproductive Health Care and Confidentiality.

FIGO statement on Ethical Aspects of the Introduction of Contraceptive Methods for Women.

FIGO statement on Ethical Aspects of Induced Abortion for Non-Medical Reasons.

Appendix: Instructors' Guide

The purposes of the FIGO Introduction to Principles and Practice of Bioethics are to make medical students of obstetrics and gynecology, and interested practitioners, aware of key concepts in bioethics, and to provide them with some case-studies to acquire some early experience in their application.

Students are expected to review the case-studies, supplemented by further real-life cases drawn from their own developing experience, in light of key ethical principles. They should identify principles that they consider relevant to a case-study, the level at which they find that principles should be applied, and the priority that should be given to principles in order to make one more relevant to any other to ethical decision-making.

The case-studies are not designed to have "right" answers. We learn as much from errors as from making "right" decisions, and we learn from our own errors as well as from those we perceive our colleagues to make. Students must therefore be given opportunities to make choices that others, including their instructors, consider ethically flawed or indefensible. Instructors must not initially direct or unconsciously guide students to make what seem to be acceptable decisions. Some options presented in the case-study Questions appear to be misguided, but it is for students to reach their own conclusions. Only after students have reached their own conclusions should they be further questioned in order to expose any flaws or concerns that may arise in their ethical reasoning. They must at first be allowed to make errors, in order for instructors to explain the points in their reasoning at which errors have arisen.

They should be required to explain and justify their proposed decisions in terms of the ethical values they find to be at stake, explain why they consider others' different perceptions and priority of values to be less preferable than their own, and respond to points that instructors raise to test whether their reasoning and conclusions can bear the weight of ethical examination.

Students should not feel bound to change their conclusions on cases simply because they find classmates' or instructors' different conclusions to have an ethical foundation. There may be more than a single ethically acceptable resolution to a question raised in a case-study, and in a real-life situation. Students should aim to reach and justify resolutions that they find ethically appropriate, even while recognizing that other resolutions, giving priority to competing principles or a different level of approach, may also be ethically defensible.

Instructors should try to contain consideration of the case-studies to the simple fact patterns in which they are framed, and not allow students to develop additional facts that permit resolutions of cases on medical, social, scientific or other grounds that evade the students having to come to grips with their ethical aspects. In real life circumstances, there may indeed be strategies that relieve ethical dilemmas, such as increasing supplies of resources or bringing in additional personnel, but in addressing the case-studies the

ethical issues should be addressed on their own terms, and not be avoided by technical additions of facts. Within the terms of a case-study, however, students should be allowed and encouraged to find additional ethical questions and options for resolution that merit attention.