

## **Ethical Dilemmas in Reproductive Health: Experiences of 10 Midwives**

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### ***Introduction***

An ethical dilemma is a situation in which an individual needs to make a choice between two or more morally acceptable options that he or she can reasonably and morally justify or existence of a problem without a satisfactory resolution (Beauchamp & Childress 2001; Mc Connell 2002). In each scenario, one action must be chosen because performing both actions would be impossible. The importance of ethical decision-making lays in the fact that very different ethical choices regarding the same ethical dilemma can be made resulting in neither choice being a “right or wrong” decision.

### ***Ethical Principles***

The ethical principles provide a foundation for nursing practice. Ethical principles are defined as the basis for nurse’s/midwife’s decisions on consideration of consequences and of universal moral principles when making clinical judgments. The most fundamental of these principles is the respect for persons.

Ethical decisions made by the nurses /midwives are based upon the classes of principles of nursing and midwifery ethics which are underpinned by the ethical principles. However depending on an individual’s personal beliefs, values and experiences in a given situation, very different choices may be made involving the same dilemma. Most moral dilemmas in nursing / midwifery can be identified according to the following classifications:

The primary and basic ethical principles:

**Respect for autonomy** - agreement to respect another's right to self-determine a course of action; support of independent decision making.

**Non-maleficence** – avoidance of harm or hurt; core of medical oath and nursing ethics.

**Beneficence** – Active promotion of good; consider the best for the patient.

**Justice** – Promotion of equity in every situations; fair allocation of resources and treatment according to emergencythe secondary ethical principles that can be incorporated with the primary principles when interpreting ethical issues and making clinical decisions are the following:

**Veracity** - Truthfulness or telling the truth

**Confidentiality** – Concerning patients/clients information, treatment that can be disclosed with patient’s consent, except when needed for law or duty

**Fidelity** - This principle requires loyalty, fairness, truthfulness, advocacy, and dedication to our patients. It involves an agreement to keep our promises. Fidelity refers to the concept of keeping a commitment and is based upon the virtue of caring.

Midwifery is dynamic and ever changing specialized field of nursing involving the care of women and childbearing families (Kinnane 2008). The code of Ethics for midwives states that Clients are central to the practice of midwifery and thus their wellbeing is the main focus for midwives. Midwives face ethical dilemmas on a daily basis regardless of the level of facility where they practice; their varied roles are faced with ethical decisions that can impact them and their patients/clients, family members, and health care organizational policies and administrators. The following are some examples of ethical dilemmas as narrated by some 10 midwives<sup>9</sup> are from Kenya and 1 midwife from Rwanda but currently a master student in Kenya.

### *Case 1*

A certain woman had been married for 4 years and really wanted to get pregnant. She finally got pregnant and was happy and looked forward to the birth of her baby. At 29 weeks of gestation, she developed severe pre-eclampsia and termination of pregnancy was inevitable. It was a difficult decision for the woman and her husband who had waited for this pregnancy. Termination of pregnancy according to the woman and her husband was not an option because it was against their faith. After much counseling, the woman and her partner accepted to consent for the termination of pregnancy but this disturbed them for a long time.

### *Case 2*

A pregnant woman who was being followed up at the cardiac clinic for management of congestive heart disease grade II was admitted with difficulty in breathing. She was Para 0+2 gravida 3. The gestation age was 12 weeks via ultrasound. Echocardiogram showed pulmonary hypertension in pregnancy. After comprehensive assessment by the cardiologist and the Obstetrician, the health team concluded termination of the pregnancy would save the life of the woman. The woman refused to consent for the termination after being given a detailed report about her physiological changes and the fate of her life.

She was subjected to several counseling sessions but her final decision was to have a baby. She was kept in the ward under medication (digoxin, lasix, and ceftriaxone ), close monitoring of the vital signs paying attention to dyspnoea. She was advised to maintain total bed rest and was nursed on sitting position. Daily legs exercise was done to prevent deep venous thrombosis.

At 28 weeks of gestation, she started deteriorating but still she could not consent for the termination. The health team was stuck, the relatives were involved but she could not accept to consent. Family counseling was done progressively but all in vain. The family members were also looking forward for a baby from this woman. Later she succumbed to death while still pregnant.

Dilemmas: In scenario 1 and 2 above the dilemmas encountered are:

Autonomy and respect for persons and beneficence. In Kenya, the Penal Code, as amended in 2010 (article 26), generally prohibits termination of pregnancy. Termination of pregnancy is legally allowed to save the life of the woman, to preserve physical health and to preserve mental health. A termination of pregnancy must be performed by a certified physician, with the consent of the woman and her spouse. Two medical opinions, one of which must be from the physician who has treated the woman and the other from a psychiatrist are required before the termination of pregnancy is performed. The termination of pregnancy must also be performed in a hospital.

The ethical requirement for autonomy need not conflict with physicians' overall ethical obligation to a principle of beneficence; that is, every effort should be made to incorporate a commitment to informed consent within a commitment to provide medical benefit to patients and thus respect them as whole and embodied persons.

### Case 3

A 40 year old woman, para 4+0 Gravid 5 came to the maternity unit with complaints of lower abdominal pain and drainage of liquor four hours earlier. She was a single mother working as a casual laborer in a flower farm referred from a dispensary and had not attended antenatal clinic. On examination fundal height 24 weeks, cervix 7cm dilated, cephalic presentation, with strong contraction lasting 45 seconds. A diagnosis of premature labour at 24 weeks was made. The woman was admitted for monitoring. After 1 hour, she delivered a 600gram male infant with anencephaly. Immediately the woman saw her baby, she sighed with a relief and asked "will this baby survive?" The APGAR score was 4 in 1 minute. I replied "the baby is alive and we will do our best." But first we have to admit your baby to the nursery for further care." She touched the baby and asked me to leave it with her. "I have 4 children, God wants to take this one away, so please let it go" she said.

### Case 4

An 18 year old woman had a premature twin delivery. 1<sup>st</sup> twin weighed 750grams and succumbed to death; the 2<sup>nd</sup> twin weighed 650grams and survived but needed advanced neonatal care. Upon delivery the parents were advised to be referred to a facility which could offer advanced neonatal care. They refused to be transferred as they believed the baby would not survive and they also had limited financial resources for any anticipated cost related to transfer. At one time they wanted to be allowed to go home and leave the baby to die.

In scenario 3 and 4, the dilemmas faced are those of: (i) **Justice**. Kenyan constitution (2010) on the bill of rights under article 43 says that "Every person shall enjoy the rights and fundamental freedoms in the Bill of Rights to the greatest extent consistent with the nature of the right or fundamental freedom." Article 26 contains 4 clauses on the rights to life which state that: 1) Every person has the right to life; 2) The life of a person begins at conception; 3) A person shall not be deprived of life intentionally, except to the extent authorized by this constitution or other written law; There was no fairness to the newborns because despite being premature or with congenital anomaly, they have a right to live. (ii) **Autonomy and respect of persons**. The woman's respect of autonomy is well applicable if she is well informed. The ethical principles of respect for autonomy, when applied in practice, generate obligations that safeguard the patient's best interests (Beauchamp and Childress (2009). 'Respect for autonomy' promotes the woman's freedom of choice, which incorporates her wish to bring her own perspective to bear on her decision-making. This is a conflict between the needs and rights of the woman and the needs and rights of the fetus. It is respect for the woman's autonomy that underpins the requirement for informed consent (Worthington, 2002). The ethical dilemma presented in these cases is whether to respect the mother's autonomy or ignoring her wishes by providing the right care. (iii) **Beneficence**: The principle directs the healthcare provider to act in the patients best interests. The nurse had to provide advanced neonatal care to the neonates.

### Case 5

A patient X is a 26 years old primigravida, who presented at 36 weeks gestation for her normal antenatal clinic in a facility, she explained that she would like to be induced the following day because her mother was very ill and was due for surgery in the next three days and her prognosis was poor. The patient reported that she would like her mother to see her baby prior to the surgery. She and her immediate family were worried that her mother may not survive the operation. She had started her antenatal clinic at 24 weeks, and all parameters were within the normal range. Her supportive family members included husband, aunty and most fundamental the ailing mother. The client was worried especially when speaking about the condition and pending operation of the woman. The client insisted that she wanted the baby born before her mother's operation, given that the client was the only child of the ailing mother. Following consultation with the medical officer in charge we were forced to do as per the client's request and the team decided to induce her the following day. Dilemmas (i) **Autonomy**: The ethical dilemma presented in the case is whether to respect the client's decision to be induced or not. (ii) **Justice**: In this situation the health worker was concerned about the induction with no compelling indication. Respecting the client's autonomy yields satisfaction for that person while interfering with an individual's autonomy the fetus. (iii) **Beneficence**: As a midwife, the risks and benefits of induction should be weighed.

### **Case 6**

A 26years old parity 3+0, sustained a second degree perineal tear during delivery. She declined to have the tear repaired claiming that in all her previous pregnancies, she has never been sutured. Despite the explanation of the importance of perineal repair she declined. The ethical dilemma in this case was the decision of doing what will benefit the client (beneficence), always avoiding harm (non maleficence) and the dilemma of autonomy where the client decisions must be respected as long as the client is well informed

### **Case 7**

A 22 years old para 1+0 gravid 2patient is admitted to labour ward as a referral from a certain district hospital in a semi-conscious state. On examination the patient had frank per vaginal bleeding, was severely pale and no fetal heart heard upon auscultation. Fetal parts were easily felt on abdominal palpation. The patient had given a history that two years ago she had been done a caesarean section due to ruptured uterus where a fresh still birth was extracted.

The patient was rushed to theatre. Upon laparotomy a complete rupture of uterus was confirmed which involved all the muscle layers of the uterus. A fresh male still birth was extracted with a birth weight of 3.2kgs. The dilemma was that that was the 2<sup>nd</sup> time she had had a ruptured uterus. Should the uterus be repaired for the 3<sup>rd</sup> time to allow this woman have another chance of having a child, bearing in mind that she has no any living child, If this is done aren't we breaking the principal of beneficence which states that the risks and benefits should be weighed and only give the care whose benefits outweigh the risks. If the uterus is repaired how sure are we that she will not have another uterine rupture which may be fatal. This may mean that we are being maleficent.

The principle of non-maleficence states that do no harm. If total hysterectomy is done aren't we denying this woman the chance of ever getting another child? And if we have to do total hysterectomy the patient is not in a condition to give consent for the hysterectomy. Who should then consent in this case on behalf of the patient?

### **Case 8**

Mr X expressed his concerns to midwife N, that he was very much concern that he may not be the biological father of the baby his wife was expecting. He asked for assistance though he was very discrete and vague about how he wanted to be helped. He was very clear about one thing; he did not want the wife to be told about his feelings. It happened that the midwife N shared this confidential information with the client. The dilemma faced by the midwife here was that of confidentiality regarding the communication with the patient's husband and veracity in telling the truth to the patient.

### **Case 9**

During the course of my practice, I met a couple who had no children despite being in a relationship for twelve years. The woman had been treated for primary infertility for five years where she had several investigations done with no problems identified. The husband likewise had investigations done at the same clinic and was diagnosed with severe azoospermia. They were later informed and counseled about their chances of not having children of their own unless they settled for adoption.

The wife confided in me that she was capable of conceiving after consulting a second gynaecologist. The gynecologist advised her that; if she desperately needed a child then she should attempt elsewhere because the husband could not make her pregnant. She opted to get pregnant outside the wedlock. The client's husband sent me a message expressing concern that he may not be the responsible biological father hence needs further confirmatory investigations. The woman continued with her antenatal clinic, amidst fears and threats from the husband. The husband sought assistance from the midwife to confirm if he was the biological father to the baby being expected.

The dilemmas in the above two scenarios are:

- 1) Confidentiality
- 2) Beneficence
- 3) Non-maleficence

Midwife breached the principle of autonomy which posed a great disagreement between the client and her spouse which impacted equally on the principle of beneficence and non-maleficence for not avoiding inherent risks. As it is the duty and responsibility of the midwife to minimize harm and maximize benefits

According to two decision models (Thomson and Thomson 2002), (Casell and Redman 2000) the obligations of a midwife seek to understand on the following: Does a midwife have an ethical obligation to maintain confidentiality when a client's husband discloses personal and sensitive information?

According to the midwifery code of ethics, midwives are bound by duty to confidentiality (NMC, 2004), yet there are times when sharing information is important as it will be in the best interest of the woman and the baby. The need to discuss what information is to be shared is paramount and when advised on the rationale behind sharing of information, most people are willing to give their consent (Beauchamp and Childress 2001). Therefore, as a midwife, he/she needed not to have been drawn to this sensitive discussion between the couple.

### Case 10

A mother who had lost her first born child due to fetal distress was admitted to a certain hospital in labour. During her examination, she was diagnosed to be having fetal distress in the first stage of labour. There were two options for her management which included an ethical dilemma. She was either to be transferred to another hospital 150 kilometers away or to have a caesarean section by her husband who was the only doctor at the hospital. The husband finally decided to perform the caesarean section and save the life of the mother (his wife) and their baby instead of transferring her and probably losing the baby on the way.

The dilemma in this situation is that of beneficence (active promotion of good; considering the best for the patient) and breaching the professional code of ethics that prohibits a health care professional such as a doctor from operating on his own wife.

### Conclusion

In caring for pregnant women, practitioners should recognize that in the majority of cases, the interests of the pregnant woman and her fetus converge rather than diverge. There is a need to promote pregnant women's health through advocacy of healthy behavior. Policy makers, legislators, physicians and nurses/midwives should work together to find constructive and evidence-based ways to address the needs. The ethical dilemmas that arise should be addressed in a manner that the safety of the mother's life takes first priority. This should include the development of safe, available, and efficacious services for women at risk and their families.

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