ETHICAL SCANARIOS O+G

INFORMED CONSENT

- **Duty of care** to provide both descriptive and quantitative description (depends on the patient)
- Understands all the risk, benefits and consequences of proposed treatment
    - Nb: a risk is any material that if given to any reasonable person in the patient's position, it would be cause the person to attach significance to it: *Rogers v Whitaker*
- *LEGAL*: informed consent/failure to warn matters, the injured party need only prove that they were touched (treated) and the onus is then on the defendant to prove that they had lawful justification (consent).

Medical Negligence ("duty of care")

- **Duty of care** = legal obligation to make reasonable precautions to avoid causing immediate or foreseeable har (automatic establish doctor-patient
    - **Nurses: failure to identify early deterioration (e.g. non-reassuring CTG trace), failure to escalate care**
    - Doctors: delayed response, Failed to identify/document/communicating risks of stillbirth, failure to act upon risks
- **Elements Negligence** – **breech of duty of care** – failing to do something that is reasonable → causing personal damage, injury or loss
    - **Plantiff Cannot** give evidence about in hindsight evidence (too much bias) BUT only needs to prove that the negligent act or omission has **materially contributed** to the risk of harm occurring [**breach of duty**] → e.g stresses prior to the incident (e.g. highly anxious mother prior to event etc.)
    - **Causation** = Onus now shifts on defendant to prove that the negligent act or omission had no bearing no effect on the risk of harm occurring at all → Will i.e. will there be the **same** outcome *despite* being a breech in negligence?
- **Standard of care =** care and skill of the ordinarily skilled professional within that profession ((e.g. intern vs reasonable intern) : *Rogers v Whitaker*
    - **SECTION 5O of the CLA – aims to** protects health professional against negligence claim → *Court evaluates the defendant's conduct against the relevant standard of care, in order to determine whether the defendant has breached their duty of care*
    - *Requires 2x witness from the defendant and the plantiff* of equally qualified specialty

MIDWIVES AND DOCTORS PROFESSIONAL INDEMNITY

- **Every health professional (doctor) must operate w/ appropriate professional indemnity cover**
- **Currently, midwives who provide support for birthing privately do so WITHOUT professional indemnity insurance**
    - This means that they do so at their own financial risk or, depending on the midwife's financial circumstances, the risk transfers to their clients should an adverse event occur, leaving a woman with no recourse to financial compensation.
    - This lack of professional indemnity cover for midwives is a barrier for midwives to pursue private practise
- **Australia's National Publicly-funded Homebirth Consortium → 12 publicly funded Australian homebirth programs in NSW, VIC, SA, WA and NT**
    - Indications: low-risk pregnancies
    - Professional indemnity insurance provided to midwives by their respective hospital

Health Records and Information Privacy Act 2002

Patient age at date of last entry	Keep record at least
Infant (obstetric records)	For 25 years from child's birth
Under 18	Until child turns / would have turned 25
18 or over	7 years from date of last entry

Clinical Case 1 – Emergency Caesarean – Informed Consent

An emergency Caesarean section is coded as Category One if it is judged that there is "*an immediate threat to the life of the mother or baby*". In these circumstances the mother will usually have been given narcotic analgesics, and everything happens very quickly. How can the ***ethical principles of informed consent*** be preserved in these circumstances?

Key issue	➢ Scenario centres around ability to give informed consent → ➢ **What is important as part of informed consent?** o Do they have capacity to make consent – i.e. do they have rational thought process? [judgement of medical practitioner] o informed of all risks, benefits and alternatives to the proposed treatment o Must advise patient they can withdraw consent at any time ➢ **What is they can't consent?** o No consent necessary as cannot consent o If they have capacity – they can refuse life-saving treatment
Ethical issues	➢ **Autonomy + Beneficence:** *Ante-natal care/visits* critical to discuss birth plan – what would happen about emergency CS? – should get informed consent at that point in time where their decision is not clouded ➢ **Autonomy + Beneficence**: Speak to both mother and partner – suggest emergency section → emphasise we need to save both lives rather than losing both lives ➢ **Maleficence**: Acts against consent = assault ➢ **Justice/equity:** Has the ingestion of narcotic medication rendered that person incapable of having capacity to provide consent? o NB: Different individuals will have a different effect on medication, which means it is always a case-by-case basis
Legal issues	➢ Importance of notion of consent at common law. It is the defendant's onus to prove that they had a legal justification (consent) for an assault (treatment) → as defendents rarely have proof → emphasizes importance of patient's autonomy to underpin consent ➢ Extent/Scope of informed consent. The consent provided generally only covers intended procedure. Requirement for consent can be waived if additional treatment is reasonable and necessary in the circumstances **NOT** merely "convenient".

Clinical Case 2 – Conduct of mother placing fetus at risk – ethical and legal obligations

When, in the process of managing a pregnancy, you form the opinion that the neglect or conduct of the mother is placing the unborn fetus at risk, what are your *ethical and legal obligations*, and what should you do about it?

Key issue	➢ Duty of care - Obligation to provide a best possible standard of care
Ethical issues	➢ **Duty of care to the mother** ○ **(how can she be helped to minimise the potentially harmful behaviours? – e.g. substance abuse (methadone program)** ○ documentation, procedural tasks, extended care and the delivery process ➢ **Duty of care to the fetus →** protect baby from substance abuse ○ **Mandatory reporting** of risky behaviour (drug/substance dependent abuse, Domestic violence) noted during pregnancy → need to create birth alert via **DCJ** prior to childbirth (marked as high risk) → DCJ assesses situation to determine if child is at risk ➢ **Respecting the mother's autonomy PLUS Communication, trust and building a relationship – longitudinal care in pregnancy** ○ Understand fundamental problem (e.g. substance abuse, domestic violence) – supporting them and the fetus throughout this pregnancy – does the mother actually know they are doing harm? ○ Offer and advise for programs available (e.g. methadone program - for narcotic usage)
Legal issues	➢ **At common law → we (doctors) have a** duty of care to the fetus to take reasonable precautions against foreseeable risks of injury. ➢ Depending on the circumstances, medical practitioner could be liable for injury to the: ○ **Fetus** (only liable if fetus is born alive – i.e. takes their 1st breath). ○ **Patient if fetus were to miscarry or be born stillborn** (if patient suffers from recognised psychiatric injury as a result). ➢ Reasonable precautions **must** be enforced (e.g. if intervention/conduct has potential to harm fetus, we must warn this to patient before doing so) . ➢ Zoe's law *"born alive rule"* = NSW Government has passed the *Crimes Legislation Amendment (Loss of Foetus) Bill 2021*. ○ Section 54A – Offence of Causing Loss of a Foetus: Legal offence if act causes loss of a foetus in pregnant women (i.e. least 20 weeks' gestation OR body mass of at > 400g) ○ Adds additional years to sentence (usu. 3 years) ▪ **MUST** Name of the unborn child to be included in the indictment (the official criminal charge); ▪ **MUST** Allow families to receive funeral expenses for the unborn child ▪ **DOES NOT** Bestow the fetus with *ANY* separate legal entity i.e. does not change the "born-alive" rule

Clinical 3 – Children under the age of 14 years – parents' beliefs at JW's influencing their decisions

When, in the process of managing a child **under the age of 14 years**, you appreciate that the parents' beliefs as **Jehovah's Witnesses**, are placing the child at **risk**, what are your ethical and legal obligations, and what should you do about it?

Key issue	➢ Informed consent ➢ Duty of care
Ethical issues	➢ Child NOT yet old enough to consent at common law pursuant to Gillick Competency (*Mature Minor Principle*). ○ Parents remain active decision makers in this case ○ However, If >16yo → Gillick competence → they can make decision for transfusion against parental wishes. However, if life-threatening they cannot refuse the treatment ➢ Duty to obtain informed consent **applies to patients (or parents) refusing treatment** too. ○ So even if views of parents were to frustrate you, need to ensure that you provide them with all of the information that they require in order to be informed when they *refuse* the treatment. ▪ E.g. Cannot have surgery (if they can't have transfusion) – e.g. craniofacial malformations in child ○ Need to maintain rapport with both parents - open discussion (risks vs benefits) + identify compromises (TXA, non-blood products)
Legal issues	Always a case-by-case basis ➢ Documentation = critical to detail whether Benefits, risk and consequences were discussed ➢ **Exception**: urgent treatment for a child to save life or prevent serious damage to health (s174 of the Children and Young Persons (Care and Protection) Act 1998 (NSW). ➢ **Further exception**: obtaining order of Court or Tribunal to carry out treatment.

Clinical Case 4 – Decision between saving mother or child

In anticipation that you might, one day, be placed in the invidious position of having to decide whether to save either a mother in labour or her unborn child, (you are unable to save both), what are the ethical and legal principles that might help guide your decision?

Key issue	➢ Duty of care as a medical professional ➢ Capacity for informed consent (See above)
Ethical issues	➢ An unborn fetus is **considered part of the mother**. ➢ Fetus ONLY becomes a legal entity once born alive. **Duty of care to mother and fetus but ethical grounds to:** ➢ *prioritise mother:* 1. Mother is already the patient whose wishes may potentially be ascertained 2. Potential for mother to succeed with subsequent pregnancy → societal benefits 3. Potential impact if future child feels responsible for mother's death ➢ *prioritise fetus*: 1. emotional impact on partner left behind 2. No more future children 3. agreed capacity for consent→ If she is adamant for live birth and disregards her own life → if they have capacity to make decision → have to respect this (respect for autonomy) 4. pre-term deliveries → high resource costs to keep in NICU/SCN (may not guarantee success) 5. Birth into foster care – if single women
Legal issues	➢ Current definition of **grievous bodily harm** under the Crimes Act includes "*the destruction (other than in the course of a medical procedure) of the foetus of a pregnant woman, whether or not the woman suffers any other harm*" ➢ Zoe's law

Clinical Case 5 Teenage sex and Contraception

- Madison is a 15-year-old who has been a patient of the same GP practice since she was a baby. She made an appointment to see the doctor last Thursday, and arrived on her own. The first thing she asked him was whether he would keep everything she said during the consultation a secret. The GP said he could not provide an absolute guarantee, but he would generally keep any information given to him by a patient confidential.
- Madison then told him that she wanted to start taking the pill. She explained that she had a 16-year-old boyfriend, and was adamant that she did not want her parents to know she was sexually active and on the pill.
- The GP told Madison he did not agree with under-age sex, and refused to prescribe the pill. When she got home, Madison lodged a complaint with AHPRA about the GP, but did not tell her parents.

Key issue	➢ Capacity for informed consent of a mature minor ➢ Personal autonomy
Ethical issues	*Implications for prescribing of contraception* ➢ *That any sexual conduct engaged in thereafter is **legal*** ➢ *Want to her preserve autonomy but equally her safety* Gillick Competency of informed consent ➢ ***Between 14 and 16 years**, minor can consent to medical treatment if they satisfy Gillick competency criteria ("mature minor principle").* 1. *Must understand with maturity the benefits, risk and consequneces of undertaking treatment* 2. Doctors must ensure the sexual activity is legal (the age of the relationship, type of relationship, domestic violence) 3. *Doctors can refuse under grounds that Madison does not acknowledge the medical consequences of her decision* ➢ *Cannot refuse medically desired treatment*
Legal issues	***Depends on jurisdiction:*** ➢ Age of consent in NSW for both heterosexual and/or homosexual sex is 16 years old (used to be 18) ➢ The two individuals must not be more than 2 years apart ***Mandatory& child protection issues reporting to DCJ*** ➢ Domestic violence ➢ Suggestions of sexual abuse (Crimes Act 1900– Sexual Offences Against Adults and Children (ss61H – 80AG)) ➢ Discuss Similar Age Defence (s80AG Crimes Act)

Clinical Case 6 The Good Samaritan

You are walking down reserve road by yourself on the way to your clinical placement at RNSH when a car pulls over and the driver asks for your assistance. His female partner is in the back seat screaming and making pushing sounds and you notice there is a head on view and she is about to have a baby. The backseat is covered in blood and fluid ?amniotic. Firstly, what would you do? Consider the following: Are you obliged to help and if you do assist what is your legal liability?

Key issue	➢ **Negligence + Duty of care** as a medical professional ➢ Capacity for informed consent (See above)
Ethical issues	➢ ***Moral obligation to help those in need*** ➢ ***Maleficence = assisting can get myself endangered (e.g.*** PPE -blood and fluid → PPE (HIV, Hep B/C)) ➢ Justice/equity - strong social contract between general community and medical students/interns providing aid
Legal issues	➢ **Common law states there is no** general duty to rescue or otherwise preserve human life BUT ***Moral obligation to help –*** o Exception = Clause 155 of Northern Territory Criminal Code is a statutory obligation for all citizen's to have duty to rescue ➢ **Good Samaritan (s56 of Civil Liability Act)** o No legal repercussions w/ providing help (**Section 57 of the Civil Liability Act**) o As long as working in good faith w/o conflict of interest o Expected to deliver care in line w/ professional training (e.g. medical student vs intern vs specialist) ➢ *Main issues for litigation:* o Negligence: failure to stop and render timely assistance o the good Samaritan falsely declares medical credentials o the good Samaritan assists while intoxicated (any impairment of judgement) → subjective assessment o the good Samaritan caused the injury in the 1st place

Clinical Case 7 – Surrogate Mother

Key issue	➢ Informed consent ➢ Rights to care
Ethical issues	➢ *Surrogate mother's autonomy = nurturing baby "incubator" despite biological parents reserving the rights to have their own child* 1. *Withdrawal of informed consent (unless legally binding) from beginning to end of pregnancy* ➢ *Maleficence* 1. *pregnancy risks associated for surrogate mother* 2. *surrogate mother may choose to terminate pregnancy or commit self-harm* ➢ *Justice/Equity* 1. *taking advantage of financially vulnerable or socially disadvantaged women for personal gain of child → sets precedence for potential black market* 2. *gender inequity → surrogacy targets women (not men)* 3. *Reducing biological act into a transaction*
Legal issues	➢ ***Rights of surrogate mother and to-be parents*** ➢ **Formal written contracts (documentation and dating) w/**

Clinical Case 8 – Vaccine Refusal

Key issue	➢ Informed consent ➢ Autonomy
Ethical issues	• *Autonomy = Parent making decisions on behalf of the child (they do not have gillick competence)* • *Beneficence = Protection for child and wider community (esp. daycare)* • *Non-maleficence = side effects can cause disrepute towards health systems (not providing safe care)* • *Justice/equity = incentives discriminate against the unvaxxed (e.g. longer COVID-lockdown periods for unvaxxed)* o *Nuffield ladder of intervention =higher levels of incentives to increase uptake* o *Targetted unvaxxed population = highly educated, religious groups, 1st hand accounts of vaccine A/E*
Soln	➢ ***Main aim =*** establish rapport and encourage follow up o *Keep objective and non-judgmental about health beliefs → identify underlying reason for refusal of treatment* o ***Descriptive and quantify the risks and benefits transparently*** ➢ **Offer compromises:** o **Give one vaccine NOW and some time later** ▪ **DO NOT downplay experiences**

Clinical Case 9 – New technologies applied on guinea pig patients

Key issue	➢ Conflict of interest ➢ Informed consent

Ethical issues + Soln	• *Experimental nature / risk of the unknown = any innovation requires oversight particularly if early stages*
	• *Learning curves – mistakes cost lives*
	  ○ *Must explain the first few cases cause significant morbidity /mortality ➔ informed consent*
	  ○ *Responsibility of innovator/designer to oversee all demonstrations, faults, simulation trials and enforce parallel certification (i.e. recruit a proctor or colleague to support each step)*
	• *Conflict of interest*
	  ○ *Who stands to gain? – sponsosrhips, accolades*
	  ○ *Will intellectual property and profit get ahead of patient care/safety?*
	  ○ *May introduce coercion from surgeons/doctors to pursue particular treatments*
	• *Justice/equity = Charging additionally to pay for innovation*
	  ○ ***Beware: No-brainer innovations or orphan drugs (so effective that they should instantly be used)***
	• *Data Mx and privacy of pt information*
	  ○ *How long stored? Or archived?*
	  ○ *How will it be used?*

SPECIAL CASES: DECISION FOR ABORTION CASE

Key issue	• Informed consent • Patient autonomy

Ethical issues	➢ **Autonomy + Beneficence:** *Ante-natal care/visits* critical to discuss birth plan – what would happen about emergency CS? – should get informed consent at that point in time where their decision is not clouded
	➢ **Autonomy + Beneficence**: Speak to both mother and partner – suggest emergency section → emphasise we need to save both lives rather than losing both lives
	➢ **Maleficence**: Acts against consent = assault
	➢ **Justice/equity:** Disparities in access to services due to geographical and financial constraints
	  ○ Rural/regional Australians have differing access to healthcare compared to Australian metropolitan cities?
	  ○ Rights enshrined in **constitutions** do not guarantee access to equitable protections, esp. for regional, poor, and marginalised people

Legal	➢ As of 2021, abortion has been decriminalised in every state in Australia. ➢ **Roe vs Wade case** being overridden sets precedence for future court decisions to redefine previous cases? ○ recent decision by the Supreme Court to overthrow Roe v Wade has left States in a position to reintroduce laws prohibiting abortion.