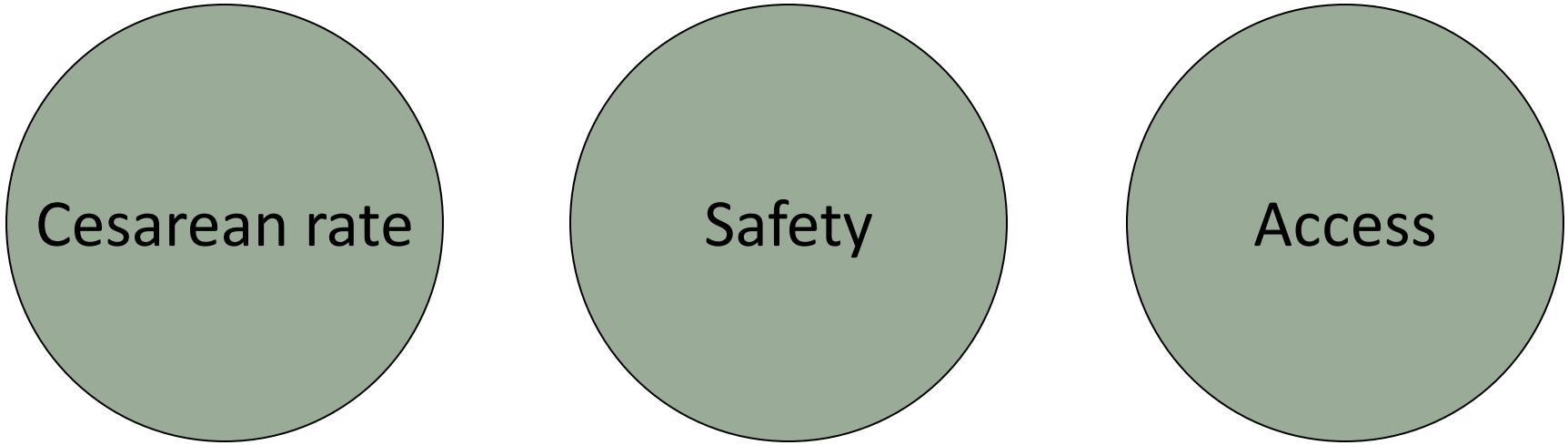
Ethics and Guideline Development: Implications for the Supporting Intended Vaginal Birth Initiative

Anne Drapkin Lyerly, MD, MA
Associate Professor, Social Medicine
Associate Director, UNC Center for Bioethics

Key issues in MOD debates



Cesarean rate

- Why be alarmed?
  - Resource allocation/cost containment
    - Justice and responsible stewardship
  - Judgment about the “right” way to deliver
    - Provider, patient, society – whose view?
  - Access to preferred delivery mode
    - Practice patterns ↓ low intervention birth

Safety

- Which risks are reasonable, by what measure, according to whom?
- What justifies directive guidelines?
- Cognitive challenges to risk reasoning
  - Low risk of very bad outcome
  - Trade-offs with valued higher probability, often extra-medical outcomes
  - Weighing maternal and fetal interests

Access

- Guidelines have potential to constrain
- Example: VBA C
  - 1990s – limited access to RCS
  - 2000s – limited access to VBAC

- Access to options ≠ autonomy
  - Too many options ↓ autonomy
  - Availability of certain options to some women ↓ options for others (CDMR)

Overview

- Four criteria for *responsible* framework
  - Safety
  - Cost-effectiveness
  - Externalities
  - Preferences

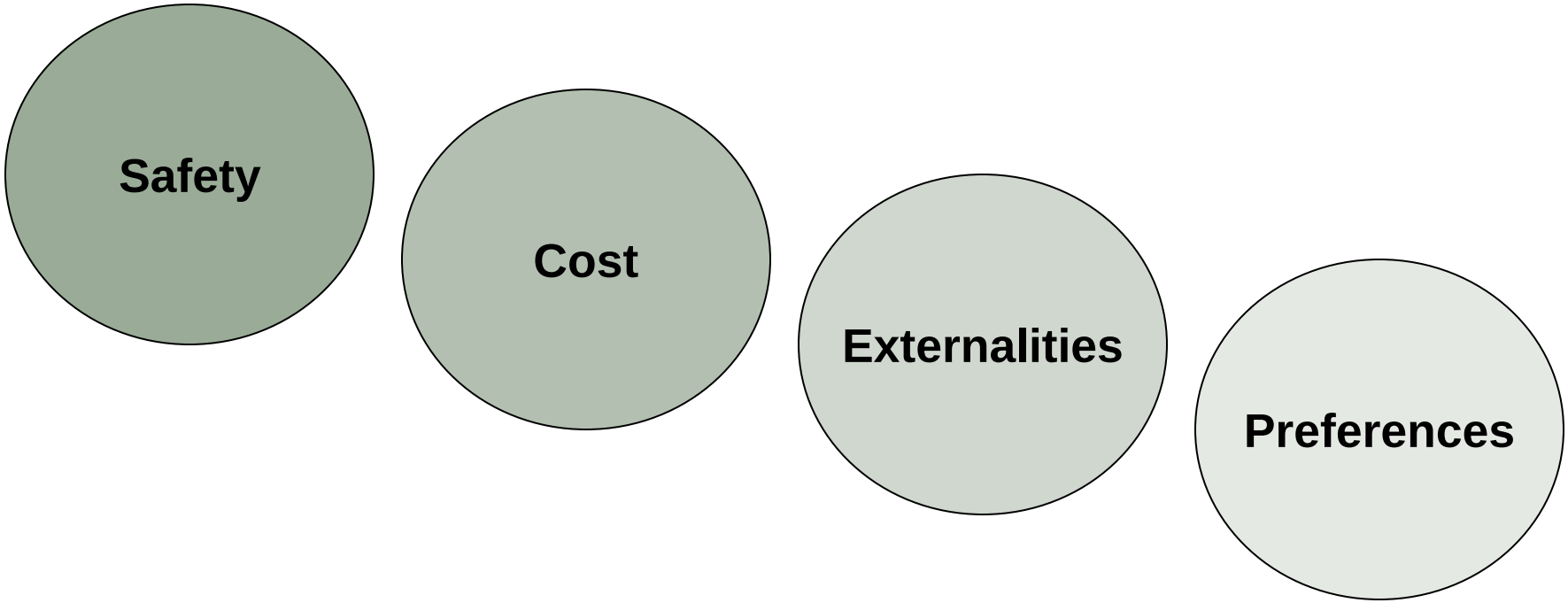
  } "scaffolding"

- Four types of guidelines
  - Non-directive
  - Presumptive
  - Prescriptive
  - Restrictive

  } distinctions

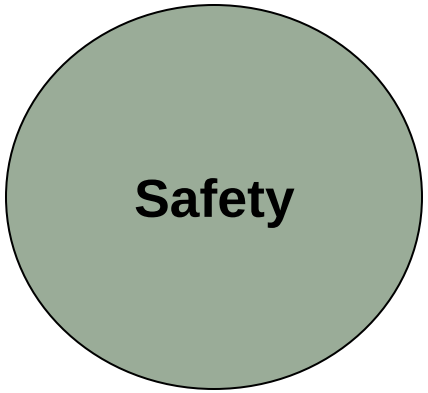
- Three caveats

Guideline development



Little et al, *Obstet Gynecol* 112; 2008

Safety



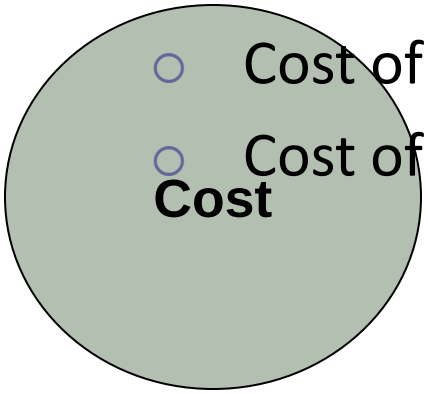
- **Probabilities** of medical outcomes
  - Maternal, neonatal
  - Short and long term

- **Value** (disvalue) of outcomes
  - RISK → Probability * value

Beneficence

Cost-effectiveness

- **Cost**
  - Cost of intervention
  - Cost of sequelae



- **Effectiveness**
  - Function of how outcomes are valued

Justice

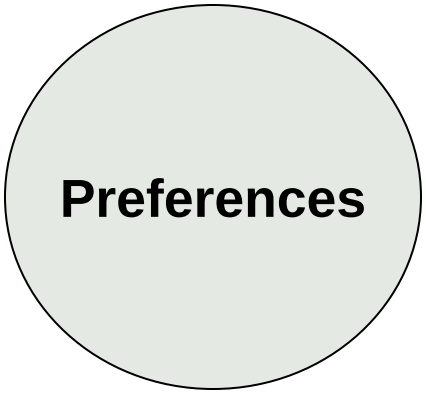
Externalities

- Broad clinical and social consequences
  - Diversion of resources
  - Shifts in institutional practices
  - Shifts in provider expertise
  - Shifts in cultural norms
- **Value**
  - Relevant to the extent they restrict desired options, set context for decisions

Justice

Preferences

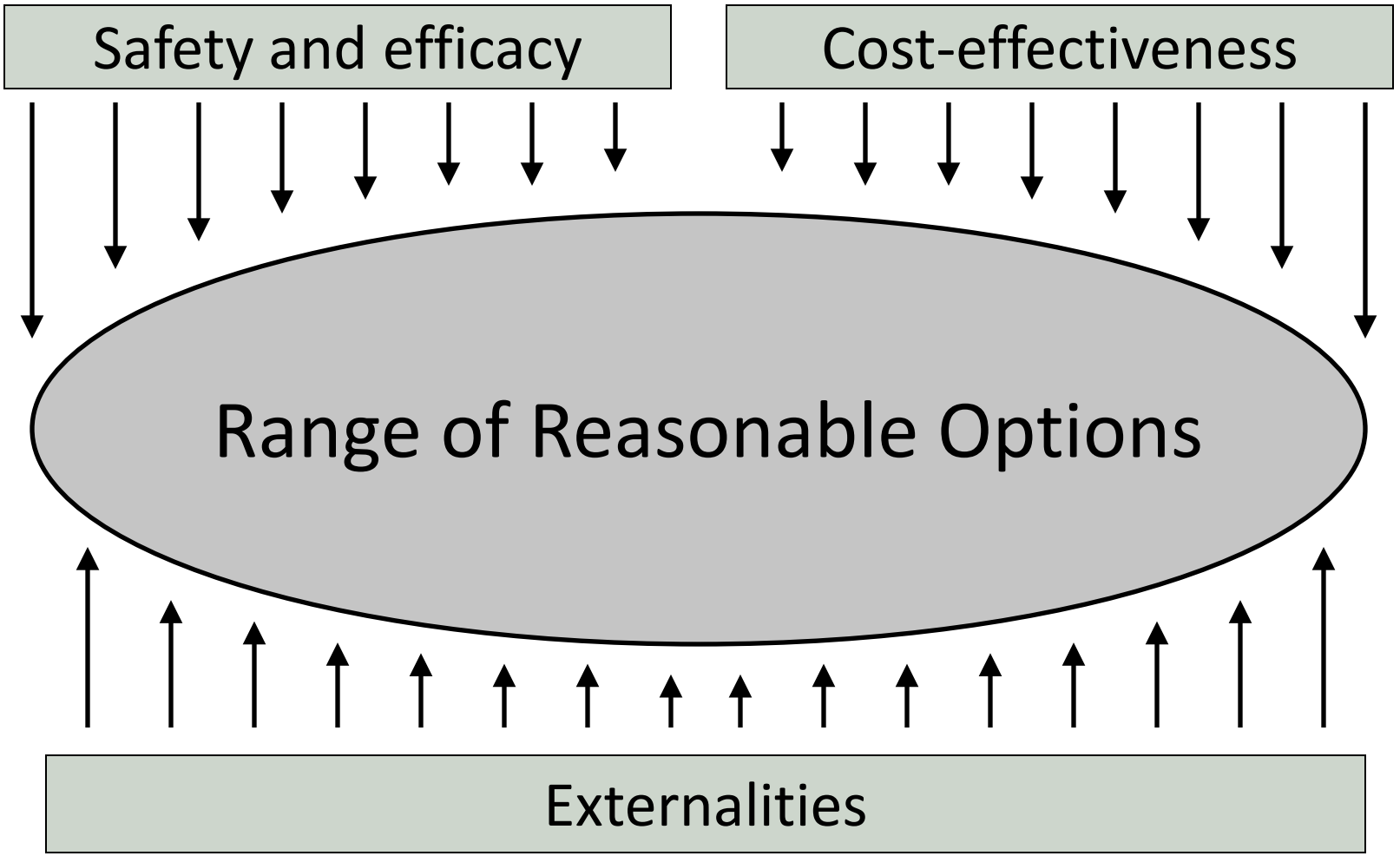
- Patient-centered considerations
  - Valuation of discrete outcomes
  - Valuation of process
  - Comparative valuation
  - Trade-offs



- Not mere preferences
  - Toothpaste type vs. MOD

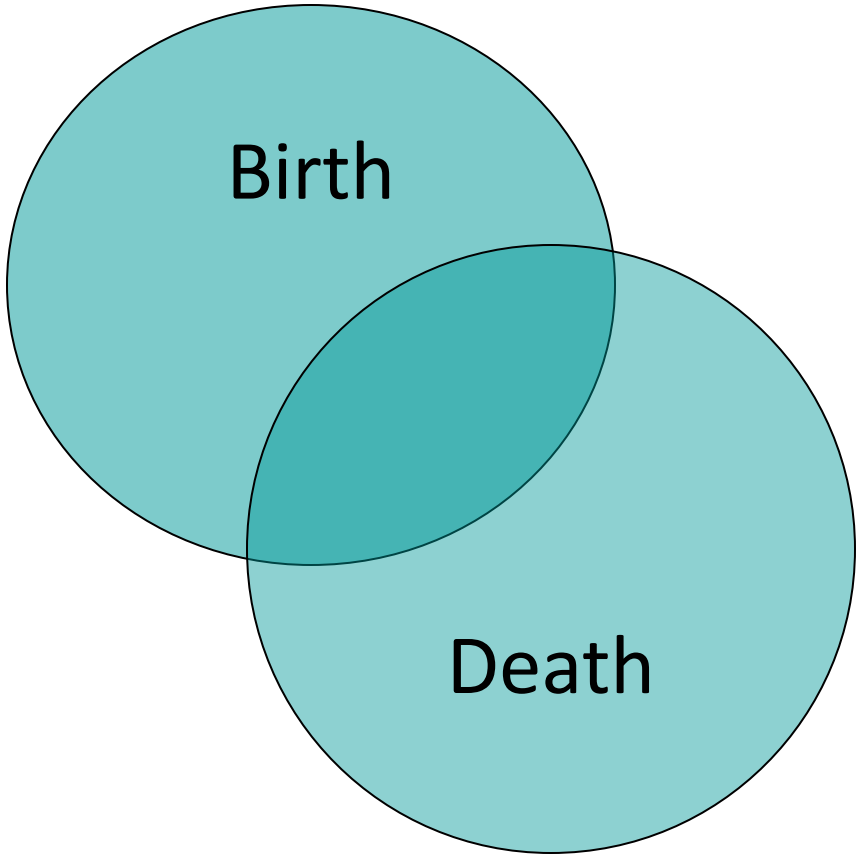
Autonomy

Framework for MOD guidelines



Little et al, *Obstet Gynecol*

Range of options in birth



- Values deeply held
- Values varied
- Process matters

- Range of options in which preferences honored

Responsible guideline development

- Four criteria for *responsible* framework
  - Safety
  - Cost-effectiveness
  - Externalities
  - Preferences

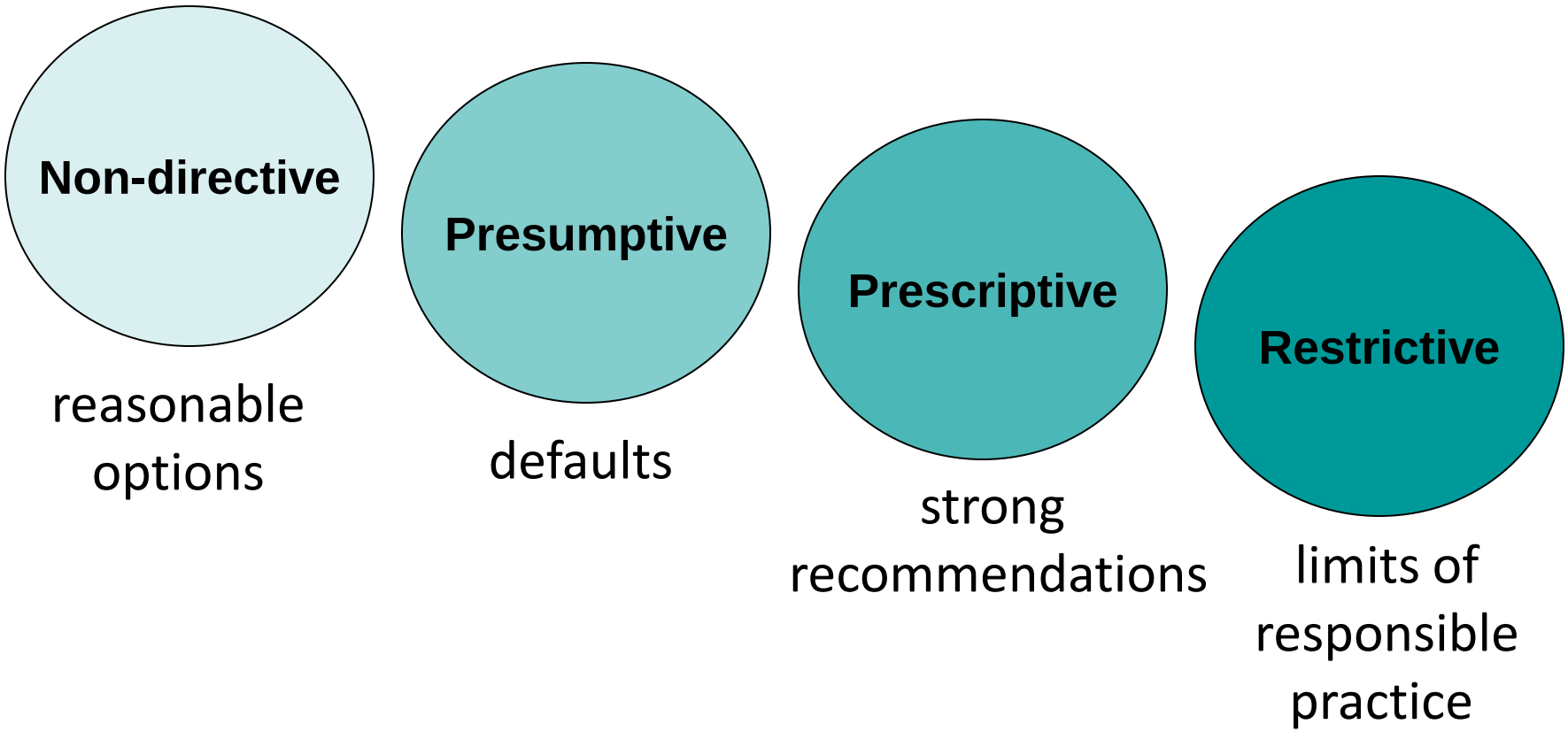
  } "scaffolding"

- **Four types of guidelines**
  - Non-directive
  - Presumptive
  - Prescriptive
  - Restrictive

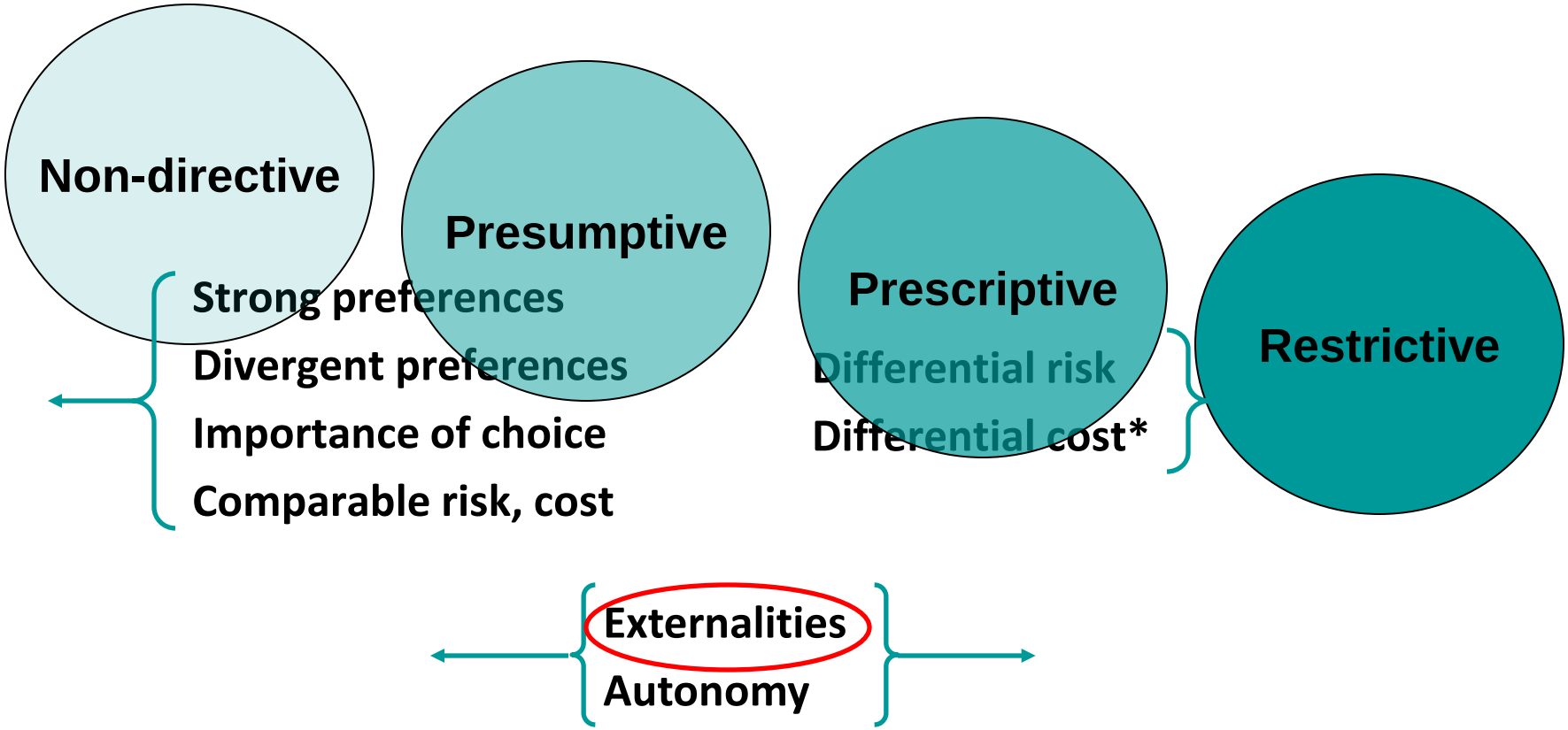
  } distinctions

- Three caveats

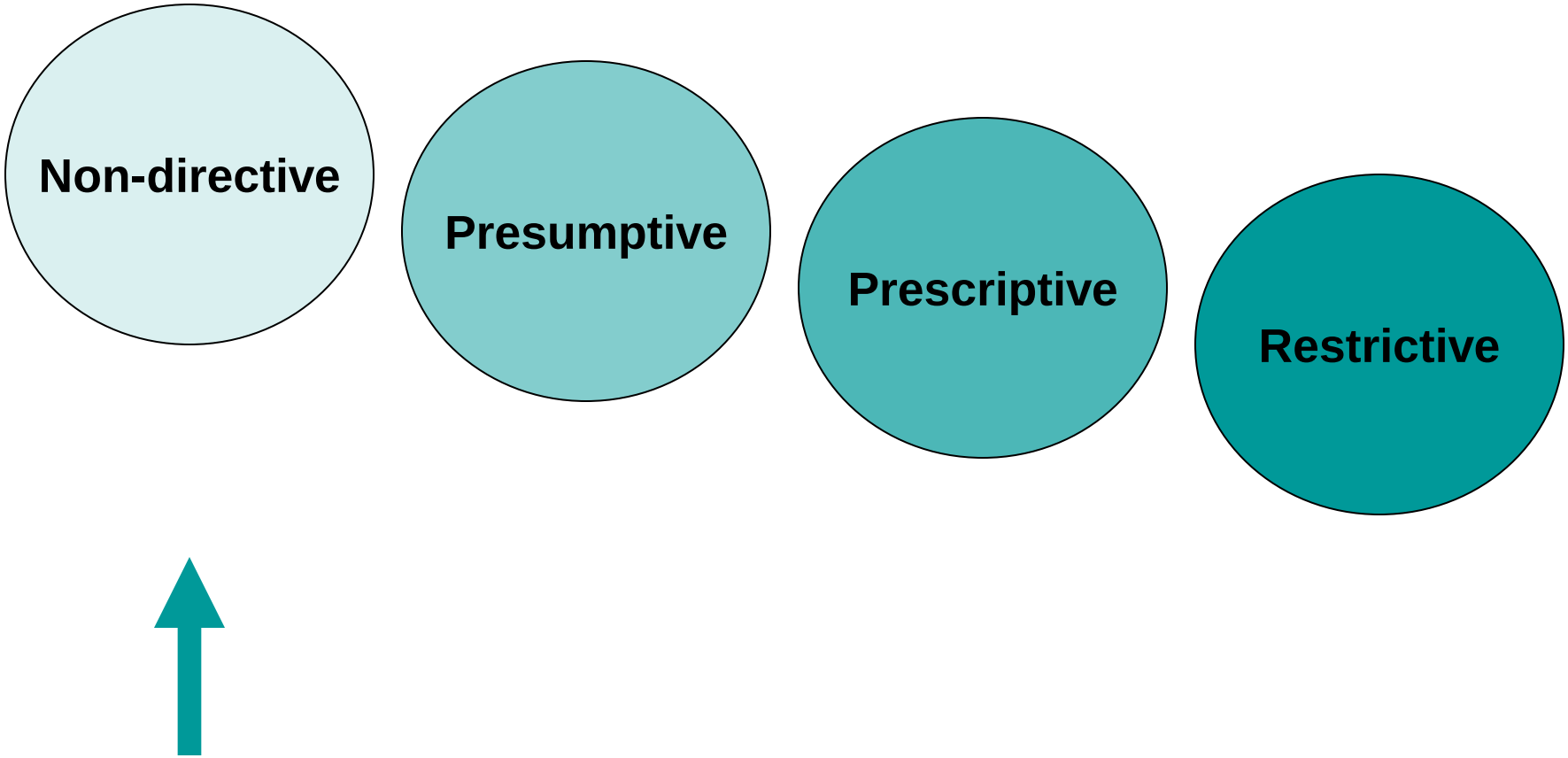
Types of guidelines



How directive?



Conflation



Challenges

- Aggregation
  - Central tendency vs. distribution
  - Population vs. individual patient
- Swamping
  - Discrete outcomes, institutional goals, provider views
  - “Quixotic quest”
- Context
  - Patient values
  - Risk elsewhere (clinical, daily life)

Conclusions

- Responsible guidelines are a function of four considerations
  - Safety and efficacy, cost-effectiveness, externalities, patient preferences
- Responsible guidelines require understanding and instituting distinctions
  - Non-directive, presumptive, prescriptive, restrictive
- Responsible guidelines require attending to challenges of risk and value