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SPECIAL ARTICLE

A Code of Ethics for the fistula surgeon

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Abstract

Vesicovaginal fistulas from obstructed labor no longer exist in wealthy industrialized countries. In the impoverished countries of sub-Saharan Africa and south Asia obstetric fistulas continue to be a prevalent clinical problem. As many as 3.5 million women may suffer from this condition and few centers exist that can provide them with competent and compassionate surgical repair of their injuries. As this situation has become more widely known in the industrialized world, increasing numbers of surgeons have begun traveling to poor countries to perform fistula operations. To date, these efforts have been carried out largely by well-intentioned individuals, acting alone. An international community of fistula surgeons who share common goals and values is still in the process of being created. To help facilitate the development of a common ethos and to improve the quality of care afforded to women suffering from obstetric fistulas, we propose a Code of Ethics for fistula surgeons that embraces the fundamental principles of beneficence, non-maleficence, respect for personal autonomy, and a dedication to the pursuit of justice.
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The vesicovaginal fistula from prolonged obstructed labor has been eliminated as a clinical problem in the industrialized world, yet it remains a women's health problem of epidemic proportions in impoverished, non-industrialized countries. Some estimates suggest as many as 3.5 million women may currently suffer from this condition, with tens of thousands of new cases developing every year [1]. Obstetric fistula can be prevented by prompt intervention once labor becomes obstructed, but lack of a functioning maternal health infrastructure in poverty-stricken countries generally precludes

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timely and effective intervention. Obstetric vesicovaginal fistulas will be eliminated only when all women have prompt access to competent functional emergency obstetric services when the need for such care arises. Until this goal is achieved, obstetric fistulas will continue to be a problem.

As obstetric fistulas have received increasing publicity over the past few years, a number of new international initiatives have arisen to increase patient access to surgical repair. Historically, surgeons attempting to repair such injuries have generally been dedicated individuals who have worked in isolation under difficult conditions to provide the surgical care needed [2,3]. As more surgeons become interested in this problem (particularly visiting surgeons from industrialized countries who may only stay in the area for short periods of time), there is an increasing need to develop common goals and a common ethical perspective of how this work should proceed. As part of this community-building process an international meeting was convened in March 2007 in Durham, NC, USA, under the joint sponsorship of the American College of Obstetricians and Gynecologists and the Duke Global Health Initiative, to discuss ethical issues surrounding obstetric fistula and the provision of surgical care to vulnerable women injured by childbirth in this way. One of the outcomes of the meeting was the development of a Fistula Surgeon's Code of Ethics, which summarizes the basic ethical obligations involved in the care of fistula patients.

In drafting the present Code of Ethics for Fistula Surgeons we have reviewed the Code of Ethics of the American College of Obstetricians and Gynecologists; the statement on Professional and Ethical Responsibilities Concerning Sexual and Reproductive rights of the International Federation of Gynecology and Obstetrics (FIGO); the Code of Ethics of the American Urological Association; the Code of Professional Conduct of the American College of Surgeons; the Code of Ethics for members of the Society for Vascular Surgery; the Code of Ethics of the American Academy of Facial Plastic and Reconstructive Surgery; the Code of Ethics of the American Association of Neurological Surgeons; the Code of Ethics and Professionalism for Orthopaedic Surgeons of the American Academy of Orthopaedic Surgeons; the Statement of Principles and Code of Ethics of the American Academy of Otolaryngology-Head and Neck Surgery; and the Code of Ethics of the Canadian Society of Plastic Surgeons. All of these surgical codes of ethics contain similar and overlapping concepts of duty, responsibility, and virtue as applied to the care of surgical patients.

This Code of Ethics incorporates the basic ethical principles of non-maleficence, beneficence, respect for patient autonomy, and a commitment to seek justice [4]. It is our hope that widespread acceptance of this Code of Ethics will help raise the standard of the care afforded to women with obstetric fistulas throughout the world.

1. *The fistula surgeon shall be dedicated above all else to providing the best possible care for women with obstetric fistulas permitted by the resources available and the local circumstances in which care is rendered. The welfare of the patient must be the overriding concern in all medical judgments made during her care, and the fistula surgeon shall not participate in any activity that is not in the best interests of the patient. Lack of resources is never a justification for the abandonment of basic ethical principles in patient care.*

Commentary: The first section of this Code of Ethics emphasizes beneficence as the primary value governing the duties of the fistula surgeon. The overarching goal of a fistula operation is to rescue the afflicted woman from her debilitating and stigmatizing condition through surgical cure. All of the efforts of the fistula surgeon should be directed toward accomplishing this goal. Surgical services should be provided in a setting that also provides psychosocial support and comfort for women afflicted with this condition.

2. *The surgeon must treat all fistula patients with respect, dignity, compassion, and honesty, safeguarding their confidentiality while recognizing that they are uniquely vulnerable to exploitation due to the circumstances in which their injuries have arisen. The ethical fistula surgeon recognizes the right of fistula sufferers to participate in decisions regarding their treatment and will not engage in any treatment or research upon them without their consent. The fistula surgeon will further strive to support decision-making processes that are free from bias or coercion.*

Commentary: Because an obstetric (or other) vesicovaginal or rectovaginal fistula is a highly stigmatizing condition, women afflicted with these conditions often become social outcasts. Usually poor, with little or no education, often young and lacking in social status, frequently physically offensive to others and to herself from the uncontrollable loss of urine or feces produced by her affliction, women with fistulas are exceptionally vulnerable to abuse and exploitation [5,6]. The principle of respect for persons mandates that these women are treated as individuals worthy in themselves, with a right to demand fairness in their treatment irrespective of their physical condition or socioeconomic status.

3. *The surgeon's highest duty is acceptance of direct personal responsibility for the care of patients on whom he or she has operated. Once a fistula surgeon has accepted a patient for care she must not be neglected. The fistula surgeon must ensure that all patients under his or her care receive an appropriate preoperative evaluation, undergo competent intraoperative treatment, and have access to adequate, ongoing, postoperative care, particularly in the critical postoperative period immediately following surgery. The pre- and postoperative care of fistula patients is the surgeon's direct responsibility, unless such duties are specifically delegated to another competent practitioner who can provide the same level of care as the operating surgeon, including a repeat-operation should it prove necessary.*

Commentary: The third section of this Code is based on principles deeply ingrained within all codes of ethical conduct for surgeons [7]. The process of surgery involves the entry into the body of one human being by another in a uniquely direct and potentially dangerous way. This makes the surgical patient profoundly vulnerable. The faith thus demonstrated in the surgeon by the patient places the surgeon in a position of enormous responsibility. Once undertaken, this responsibility cannot lightly be abandoned. Surgeons who cannot or who will not accept this

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