



## Physician morality and perinatal decisions



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### ABSTRACT

**Objective:** Given the same set of “facts” (e.g. fetal prognosis) different physicians may not give the same advice to patients. Studies have shown that people differ in how they prioritize moral domains, but how those domains influence counseling and management has not been assessed among obstetricians. Our objective was to see if, given the same set of facts, obstetricians’ counseling would vary depending on their prioritization of moral domains.

**Design:** Obstetricians completed questionnaires that included validated scales of moral domains (e.g. autonomy, community, divinity), demographic data, and hypothetical scenarios (e.g. how aggressively they would pursue the interests of a potentially compromised child, the degree of deference they gave to parents’ choices, and their relative valuation of fetal rights and women’s rights). Multivariate logistic regression using backwards conditional selection was used to explore how participants responded to the moral dilemma scenarios.

**Results:** Among the 249 participating obstetricians there was wide variation in counseling, much of which reflected differences in prioritization of moral domains. For example, requiring a higher likelihood of neonatal survival before recommending a cesarean section with cord prolapse was associated with Fairness/Reciprocity, an autonomy domain which emphasizes treating individuals equally (OR = 1.42, 90% CI = 1.06–1.89,  $p = 0.05$ ). Honoring parents’ request to wait longer to suspend attempts to resuscitate an infant with no heart rate or pulse was associated with the community domains (involving concepts of loyalty and hierarchy) of In-Group/Loyalty; OR 1.30, 90% CI = 1.04–1.62,  $p = 0.05$  and Authority/Respect (OR = 1.34, 90% CI = 1.06–1.34,  $p = 0.045$ ). Carrying out an unconsented cesarean section was associated with In-Group Loyalty (OR = 1.26, 90% CI = 1.01–1.56,  $p = 0.08$ ) and religiosity (OR = 1.08, 90% CI = 1.00–1.16,  $p = 0.08$ ).

**Conclusion:** The advice that patients receive may vary widely depending on the underlying moral values of obstetricians. Physicians should be aware of their “biases” in order to provide the most objective counseling possible.

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### Introduction

Patient counseling involves considerations of both facts and values [1]. While physicians’ medical values (e.g. beneficence) are appropriate components of counseling, personal values (e.g. favoring small families) are not [2,3]. Nevertheless, personal values of all sorts may influence physician advice.

Individuals’ personal values reflect a tacit prioritization of moral domains. Shweder et al. has suggested there are three

main cross-cultural moral domains: community, autonomy, and divinity [4]. Differences in the way they are prioritized may lead to differences in moral values and attitudes. However the role of physicians’ moral beliefs in perinatal counseling has not previously been assessed. This study was undertaken to determine how moral domains influence decisions that obstetricians make.

### Methods

This study was approved by the IRB at Maimonides Medical Center. A convenience sample of obstetricians was recruited at three venues: an annual clinical meeting of ACOG, a District II ACOG meeting, and Grand Rounds in New York City.

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A questionnaire with three sections was developed based on focus groups of obstetricians and piloted among 10 physicians for comprehension.

- (1) Demographics: gender, age, race, religion and a religiosity scale (0 = “Not religious at all”, 10 = “Very religious”).
- (2) Moral domains. The 20-item Moral Foundations Questionnaire (MFQ) 7 is a validated instrument which measures five moral domains (expanded from Shewder’s original three). Individual item consists of moral statements rated from 0 to 5 and higher ratings indicate greater personal value placed a statement. The scale includes two domains related to autonomy: Harm/Care and Fairness/Reciprocity; two domains related to community: In-group/Loyalty and Authority/Respect; and one domain related to divinity: Purity/Sanctity (note: domains will be referred to by the first word, not both the words before and after the slash, going forward). Each domain is scored by summing across items, with each domain scores ranging from 0 to 20. The Cronbach alpha values for the Moral Domain scales obtained from our sample ranged between 0.60 for Fairness to 0.71 for Purity. Comparable alpha values for the original MFQ subscales were 0.65–0.84 [5].
- (3) Moral dilemmas. Participants were asked to respond to six hypothetical scenarios. These were designed as thought experiments, with a minimum of clinical data in order to focus respondents’ answers on ethical considerations, not medical management:

Scenarios dealing with interests of a compromised child: Scenario (1) “How would you respond if a cord prolapsed at a gestational age at which the fetus had an 80% chance of death and surviving fetuses had an 80% risk of profound impairment?” Respondents were asked how strongly they would recommend a cesarean section on a scale ranging from –5 (strongly against) to +5 (strongly favor); Scenario (2) “What minimal likelihood of a child’s survival without major impairment would lead you to recommend a cesarean section if an umbilical cord prolapsed?” Participants answered this by circling a number corresponding to a likelihood ranging by 5 point increments from 5% to 90%.

Scenarios assessing deference given to parents’ choices: Scenario (3) “If an extremely preterm infant were born with no heart rate and no pulse and the parents asked you to keep trying to resuscitate, how many minutes of Apgar 0 would pass before you would ask the pediatrician to stop trying to resuscitate?” Respondents circled a number between 1 and 29 corresponding to the number of minutes they would allow. Scenario (4), “If a 500 gm baby were born with Apgar scores of 2 and 2 at one and five minutes, and the parents said stop resuscitating how likely would you be to honor their request?” Participants responded to this item using a Likert-type scale from –5 (i.e. Not honor request, continue resuscitation) to +5 scale (i.e. Honor request, stop resuscitation).

Scenarios assessing valuation of fetal/newborn rights and woman’s rights: Scenario (5) “A woman at term with no medical risks and a perfectly healthy fetus has a cord prolapse at 5 cm. She refuses a cesarean section for seemingly trivial reasons. A judge says he will grant you a court order to perform a cesarean section. Do you perform it (Yes/No)?” Scenario (6) “A newborn has a mysterious illness that will lead to death within 24 hours if it doesn’t receive a marrow transplant from its mother. The mother refuses for seemingly trivial reasons. A judge says he will give you a court order to take the marrow. Do you take her marrow (Yes/No)?”

#### Statistical analysis

Categorical data were described as frequency (percent), normally distributed continuous data were described as mean  $\pm$

standard deviation, and data with outliers as median (interquartile range). Chi square tests tested for group differences in rates or percentages while two group *t*-tests tested for mean differences. Moral dilemma responses based on a continuous scale were dichotomized using a median split due to outliers. Univariate logistic regression was used to explore predictors of responses to the moral dilemma scenarios, while multivariate logistic regression with backwards conditional selection determined the strongest predictors. Regression results are reported in terms of odds ratio.

Since this study was exploratory in nature, a *p*-value <0.10 was used as the criterion for statistical significance for whether a possible predictor was to be selected and <0.15 for retention in a logistic regression model with backwards selection. Similarly, 90% confidence limits are reported for odds ratios in agreement with the level of significance.

A prior power estimation determined that we would need a minimum of 152 participants to have at least 80% power with  $\alpha = 0.10$  to detect a minimum correlation of  $r = 0.20$  between variables, for example, the moral domain of autonomy and a participant’s willingness to perform a cesarean section. In order to carry out secondary analyses involving subgroups of respondents, we recruited additional participants.

## Results

Two hundred and fifty-four obstetricians were approached, and 249 agreed to participate; 122 recruited from the 2014 ACOG annual clinical meeting, 73 from the 2014 District II ACOG meeting, and 54 from Grand Rounds in New York City in 2014. As shown in Table 1, 26% were male, the mean  $\pm$  SD age was  $40.3 \pm 12.9$ , forty-four percent were white, 27% African-American, 8% Hispanic, 17% Asian, and 5% were classified as “Other.”

#### Moral dilemmas: distribution of responses

Figs. 1(A and B) and 2 (A and B) show the distribution of responses to the first four moral dilemma scenarios which had responses based on a continuum. While many of the responses tended to cluster around particular points along the scale, responses of the remaining participants showed considerable variability. In moral dilemma 1 (MD1), 36% of the respondents were strongly in favor of performing cesarean section in the event

**Table 1**  
Demographic characteristics of the responders.

Characteristic		
Male gender (N = 246)		65 (26%) <sup>a</sup>
Age (N = 207)		40.30 $\pm$ 12.89 <sup>b</sup>
Ethnicity (N = 247)	Black	67 (27%)
	White	108 (44%)
	Hispanic	19 (8%)
	Asian	41 (17%)
	Other	12 (5%)
Level of religiosity (N = 236)		6.99 $\pm$ 2.00
Religion (N = 236)	Hindu	12 (5%)
	Jewish	21 (9%)
	Muslim	11 (5%)
	Protestant	75 (32%)
	Catholic	58 (25%)
	>One, Other	59 (25%)
	Moral domains (N = 249)	Harm/Care
Fairness/Reciprocity		15.29 $\pm$ 3.06
In-group/Loyalty		10.29 $\pm$ 4.02
Authority/Respect		11.20 $\pm$ 3.68
Purity/Sanctity		10.61 $\pm$ 4.58

<sup>a</sup> Frequency (percent).

<sup>b</sup> Mean  $\pm$  standard deviation.

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