Requesting a patient to document her decision for refusal of hospital treatment promotes beneficence

To the Editor: We read with interest the article by Hall,[1] which reflects on the occasional conflict between patient autonomy and beneficence. His opinion is a considered one and acceptable in contemporary medical practice; however, we would like to reinforce the concept that informed consent is not a snapshot but a process in which documentation of the advice given by the medical practitioner may not only promote beneficence but take into account issues related to medical litigation. In common with the case of placental abruption reported by Hall, we present a patient who was also a cigarette smoker at 29 weeks' gestational age. She was admitted to the antenatal ward through the prenatal clinic because a small retroplacental clot had been noted on ultrasonography. She was a 32-year-old primigravida and had gestational hypertension controlled on alpha-methyldopa. Being at increased risk of placental abruption because of her smoking and the pregnancy hypertension and placental blood clot, she was informed about possible management options, including urgent caesarean delivery (CD) and expectant management. The latter was her preference owing to the risks of prematurity.

The patient received betamethasone to stimulate fetal lung maturity, and just before a scheduled ultrasound scan 24 hours later, the antenatal fetal cardiotocograph recording showed atypical variable decelerations. An emergency CD was offered to the patient, while intrapartum fetal resuscitation was commenced. The patient accepted the offer of CD and informed her mother, who advised her against the delivery, citing complications of prematurity and indicating, from a layperson's point of view, that conservative management until term was preferable. Despite re-counselling of the patient and her mother, reluctance to accept the CD persisted until the specialist obstetrician suggested that the patient should document her wish in writing. Wary about the implications of such a decision, the patient accepted the CD and was delivered of a 1 100 g baby with normal Apgar scores. A huge retroplacental clot was noted. The baby was in a stable condition, and was admitted to the neonatal unit due to low birth weight.

We reflect once again that providing information and consent is a process and requires complete documentation to confirm that both parties have the same understanding of the informed consent. In our case, documentation may have resulted in beneficence without infringing on autonomy. We, like Nienaber and Bailey,[2] endorse autonomy and the right to bodily integrity; however, our clinical experiences show that documentation of the informed consent process is essential, particularly given the high costs of medical litigation in South Africa, and that it may occasionally, as demonstrated in our case, achieve beneficence.

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