

“Futility” Questions, Baby Doe, and Mandatory Reporting

Vignette for March 29, 2019 MEH Presentation (Based on actual cases, all names and many details altered to maintain anonymity)

On February 2, 2002 Dr. Robby Prindell, chair of the ethics committee at Holman County Medical Center (HCMC), a facility located in East Carolina (a fictitious state), was called to the labor and delivery floor of the hospital for an ethics consult. At HCMC the general practice was to have the ethicist on call respond to consult requests to evaluate the issues and decide if a more formal full ethics consult was indicated.

When Prindell arrived on the unit, he was introduced to John Ralston and his wife Samina Ralston, who was pregnant—estimated gestational age (EGA) of 32 weeks. She was in pre-term labor.

Earlier in her pregnancy, Samina had seen her obstetrician, Dr. Sally Johns, one time during her pregnancy, at 16 weeks EGA. Dr. Johns had performed an ultrasound to confirm age of the pregnancy and look for any abnormalities in the fetus’s anatomy or in Samina’s uterus. Dr. Johns confirmed an EGA of 16 weeks, and was concerned, but not certain, that she detected some potentially life-threatening anomalies. She asked Samina to return in two weeks for a second, more definitive ultrasound. Having more certainty at week 16 would allow Samina to obtain an abortion prior to her 20th week EGA if the anomalies were confirmed and she decided to do so.

Samina never returned for follow-up visits with Dr. Johns. She was convinced her baby would be profoundly impaired and likely would die soon after birth. Nonetheless she was ambivalent about obtaining an abortion, and decided with her husband that she would proceed to a natural vaginal delivery. Instead she intended to prohibit the medical staff from performing any form of resuscitation, essentially establishing a pre-delivery DNR (do-not-resuscitate) status for their baby.

This intent became apparent to HCMC, leading to Prindell’s ethics consultation. A nurse caring for Samina requested an ethics consult to clarify the legal options available to the family. In 2002, East Carolina allowed abortions up to 20 weeks EGA, and past that date, it allowed abortions only for the life or health of the mother or if it was certain that the infant had no medically reasonable probability of survival past one week of life.

Prindell reviewed Dr. John’s earlier notes, and those recorded at the time of admission to the hospital. He confirmed that this pregnancy and delivery were unlikely to pose any projected risk to Samina’s life or health. Since Samina had received only one ultrasound, one that was far from definitive, it was impossible to predict what anomalies the baby would have or what her quality of life would be. As Prindell understood East Carolina law and the federal “Baby Doe” laws, the option of a pre-delivery DNR was illegal. If implemented, this would prompt a report to Child Protective Services, and if verified would most likely result in criminal charges and loss of further federal funding to HCMC. Prindell contacted the in-house attorney, also a member of the ethics consult team, who confirmed his interpretation of the law.

As gently as possible, Prindell informed the Ralstons that in East Carolina as in most states, establishing a pre-delivery DNR was an unlawful action, and could result in the outcomes listed above and potentially felony charges against the Ralstons. While he acknowledged that the Ralstons were in a difficult, heart-breaking situation, this wasn’t a difficult legal or ethical dilemma. They had asked for a course of action that was foreclosed to HCMC legally.

Upon hearing this, the Ralstons became quite angry and asked if this was the official opinion of the ethics consult team at HCMC. Prindell replied that it didn't really constitute an ethical judgment so much as it informed the family about what their legal options were and were not. He did not feel a formal ethics consult was indicated but did carefully document his discussion with the Ralstons and the in-house attorney.

Ultimately, Samina's premature labor at that point was controlled, and she was discharged.

Four weeks later Samina came back to HCMC in labor again which resulted in a normal spontaneous vaginal delivery. Prindell and the ethics consult team were not consulted. The mother had no complications. The infant, Baby Rae, while viable, had multiple organ and developmental abnormalities. She survived six weeks, during which she received continuous intensive care and underwent multiple procedures before she eventually succumbed. No autopsy was performed.

Three weeks after Baby Rae's death, the Ralstons wrote a blistering eight-page letter of complaint, naming multiple physicians, nurses, the hospital, and particularly Prindell as incompetent, uncaring, and guilty of gross malpractice. They sent copies of this to each member of the hospital Board of Trustees and to each member of the Board of the clinic where Prindell was employed.

HCMC performed a formal root cause analysis (RCA) to establish if any errors of omission or commission were made in the care of Baby Rae, and if appropriate standards of care were met in Baby Rae's hospitalization. This was not limited to Baby Rae's medical care but extended to the ethical treatment of the case.

Prindell was personally called before the RCA panel to explain his actions. Neither Prindell nor any other HCMC staff member or employee was found to be negligent or guilty of medical malpractice. The hospital risk management team met with the family. Baby Rae's and Samina Ralston's medical bills, totaling almost \$1,000,000, were waived. The Ralstons did not file a malpractice suit, though this was not a condition of agreeing to forgo a malpractice suit or maintain public silence about Baby Rae's short life and sad death. No one was reported to the National Practitioner Data Bank, a clearinghouse for medical malpractice judgments.

One of the family's complaints against Prindell was that they believed his judgments were rendered on the basis of his personal religious convictions. They based this on the fact that during a Google search, they discovered internet blog posts by Prindell that suggested he held pro-life positions on abortion and euthanasia. Prindell maintained that he did not render any ethical judgments, but simply informed the Ralstons of the applicable state and federal laws. Dr. Prindell continues to serve in his clinical and ethical roles at HCMC.

Primary Reading Assignments:

Professor Wilson's Presentation:

Please find attached a chapter entitled *In re T.A.C.P. and In the Matter of Baby K*, from Prof. Robin Wilson's book [Health Law & Bioethics](#). (This was sent via email from Chris Pecenka)

Dr. Cranston's Vignette

<https://embryo.asu.edu/pages/baby-doe-rules-1984> (relatively concise overview)

Recommended Optional Reading:

http://mn.gov/mnddc/honoring-choices/cnnReports/Moral_and_Ethical_Issues4-Baby-Doe-Kappel.pdf

This questions would be given to the students at the time of the class discussion. The vignette, above, would be distributed a week in advance of the class.

Questions for Discussion

- 1) How does one define “futility”? Are there different types of futility?
- 2) What are the essential elements of the Baby Doe laws?
- 3) What are the elements of advance directives, and what types of advance directives are legal?
- 4) “Quality of Life” predictions are often at the root of futility decisions. How does one evaluate quality of life?
- 5) Assuming that Dr. Prindell acted politely and professionally, did he commit any errors in speaking with the Ralstons?
- 6) Have you ever been faced with a similar ethical conundrum? Please answer only if you feel willing and able discuss with the members of your group. This is voluntary and we ask that any questioning by the members of the group stop immediately if the person sharing asks it to stop.
- 7) Recently, New York State passed a law that abortions performed up till the time of delivery itself are legal. What do other states say about timing of abortions?
- 8) What are the elements of a successful malpractice claim?
- 9) What is mandatory reporting, and does it apply in Baby Rae’s case? Are you a mandatory reporter?
- 10) Is it a conflict of interest to have an in-house attorney or member of the risk management team serve as an ethics consult team member? Why or why not?
- 11) If Baby Rae had survived, but was left with multiple disabilities, and required long-term, expensive medical care, would a “wrongful life” legal claim be valid?
- 12) How old does a person have to be to give consent for an umbilical hernia revision? How old must be to give consent for an abortion?
- 13) What has happened to the incidence and prevalence of children born with Down Syndrome in the US and Western Europe? Why?
- 14) How do you explain the Ralstons’ reluctance to have an abortion but adamant insistence of a pre-delivery DNR?