

Virtual Mentor

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MEDICAL EDUCATION

A Nonpaternalist Approach to Counseling Patients with Extremely Premature Delivery

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Every new physician reaches a point at which he or she feels inadequately prepared for the clinical or ethical decision at hand. The situation matches nothing learned from books and nothing seen in the clinic or hospital. This happens, of course, to every primary care and specialist physician, but when the interests at stake are those of patients who cannot speak for themselves—children, newborns, the comatose, or the unborn—the decisions seem even more confounding.

In the commentary that follows my short introduction, Katherine Singh, MD, describes the ethical concerns she had during residency about the modes of delivery for extremely premature infants. The formal curriculum of the Case Western Reserve/MetroHealth/Cleveland Clinic ob/gyn residency program doesn't integrate ethical questions like those Dr. Singh asked herself. We teach, of course, the modes of delivery for extremely premature newborns; we can give residents the statistics on survival rates for these infants and the morbidities associated with extreme prematurity. We address the legal issues—a woman's right to control her body and what cannot be done to it without her consent. And residents learn that the physician, too, has responsibilities and cannot comply with all patient requests—for example, a woman's request for an emergency cesarean delivery of an obviously previable fetus (less than 20 weeks' gestation).

Dr. Singh brings up the many clinical and ethical decisions that are unique to specific circumstances of a particular mother-to-be. In our county hospital, as in many others, these decisions must often be made quickly because the patient arrives under emergency conditions, having had no prenatal care, and unknown to any of those who are suddenly responsible for her care. Time is not always available to discuss the risks and benefits of treatment options. When it is, our job is to provide patients with information and guidance about their specific circumstances and treatment options, not to make decisions for them.

A Resident's Story

by Katherine Singh, MD

As a medical student, I knew obstetrics involved many complex medical and ethical dilemmas. The challenge of counseling and caring for a patient when the well-being of not one but two lives were in question seemed obvious. Group discussions embedded in the curriculum posed ethical questions about the delivery of previable infants. We learned about different health belief models and examined the

differences among legal, moral, and ethical principles and guidelines. The complexity of decision making was one of the many fascinations that drew me to pursuing a residency in ob/gyn.

I learned during my first month of residency, however, that no class or group discussion could prepare me completely for the real thing. During the early hours of the morning on one of my first on-call shifts, a young woman arrived at the labor and delivery unit about to go into labor after approximately 23 weeks' gestation. Her fetus was in breech position. She had had no prenatal care, so the age of the fetus was determined by ultrasound upon her arrival. She wanted "everything" done to save her baby. So many questions rushed into my mind.

Does she know what is happening? Does she understand what a classic cesarean section is and what it means for her future? Does she know about the pain, recovery time, and risks that go with surgery? Does she understand the morbidity and mortality associated with an infant of 23 weeks' gestation? Can she imagine what it is like to raise a severely disabled child for the remainder of its life—what the physical, emotional, and financial burdens are? Does she have support for her situation, whatever its outcome? What are her personal beliefs? If she didn't plead to have everything done, would she feel guilty for the rest of her life? Is the decision she makes now the one she would make if she had more time to think about it?

I felt so unprepared to help this patient with her predicament. I knew the best thing I could do was to give her as much information as possible, but, as an intern, that wasn't much. I quickly summoned the attending physician and tried to absorb everything he told her.

That is how we learn in residency. We are eager observers in our early years, and the learning curve is steep. I watched many attending physicians counsel many patients about delivery in the setting of extreme prematurity. Each had his or her own way of doing so. I observed a wide spectrum of maternal decision making and saw many outcomes. Some neonates died; some lived with many long-term problems and would never have normal lives; still others were discharged after a long stay in the neonatal intensive care unit with relatively few problems.

Seeing severely ill, suffering infants initially inclined me toward counseling a woman about likely neonatal morbidities and trying to influence her decision—"directive counseling." But soon I learned that no one can predict the outcome for any given baby, and assuming that one can is not in the patient's best interest. I sometimes found myself frustrated with the law—when for example, it dictates the gestational age at which termination of a pregnancy is legal. I know the law is there to protect the vulnerable, but its presence in such sensitive, personal circumstances can seem intrusive and blunt. The lawmakers are not those living with the consequences of a periviable fetus who dies or a permanently disabled child who survives.

Now, after four years of residency, I am starting my first of year of a maternal-fetal medicine fellowship, and here I am again—intrigued and challenged by the complexity of the ethical decisions in obstetrics. My questions about patients' beliefs and understandings remain, but I understand a great deal more about counseling patients effectively. I have learned about my style of empathy. Strange as it may sound, separating myself emotionally makes me a more empathic counselor. I have discovered the importance of being a truly nonjudgmental and nonpaternalistic provider of information. That is my job: give as much information as I can and continue until I know that the patient really understands me; bad news often needs to be repeated. These are crucial principles because, after the information is provided and the news given, it is the patient's decision to make; she will be living with it.

By watching and trying I learned the lessons that cannot be taught in the classroom. Laws and definitions can, and it was helpful to get the input of my peers during group discussions. But laws and discussions cannot prevent one from being sideswiped by real life. Only when you are alone with a patient do you learn that you must be able to look at her for feedback and communicate with her alone. It is then that you must challenge yourself to glimpse where she is coming from and how she is feeling. It is then that you learn about yourself and how you react during times of stress and confusion. Then look at the result of your work and learn how to do it even better.

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