ISSUES IN PUBLIC HEALTH

Avoiding paternalism but not moral perplexity

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Maternal autonomy has replaced medical paternalism, but conflicts between beneficence and autonomy persist.

S Afr Med J 2018;108(11):915-916. DOI:10.7196/SAMJ.2018.v108i11.13328

The second time I saw her was in the early morning hours, less than 24 hours after her first visit. The initial consultation had taken place two weeks before Christmas, on a Monday afternoon in my tertiary obstetrics clinic. Scarcely 20 years old, she was already 29 weeks into her third pregnancy and had been referred to the university hospital from a nearby town with the history of placental abruption in each of her two previous pregnancies. The first of these babies had been stillborn, but the second, delivered by emergency caesarean section with a birthweight of 900 g, was born alive despite a blood clot covering 70% of the placental surface. This gritty baby girl had pulled through and was the light of her mother's troubled life.

Now my patient was pregnant again, facing the familiar grave challenges to which she had almost become accustomed. Apart from the frighteningly high risk (20 - 25%) of repeat placental abruption conferred by her obstetric history,[1] she lived under difficult socioeconomic circumstances and was a smoker. After reviewing her records, I examined her and arranged the appropriate special investigations. Her blood pressure was normal, urine examination was clear and umbilical artery Doppler flow velocimetry to test placental function was normal too, but for different reasons we both knew that things could change very quickly. Although earlier ultrasound scans of the placenta performed at the referring hospital had the ominous finding of placental lakes, these were absent now. As I studied my young patient, integrating her history and examination findings, red lights were flashing clearly. She seemed vulnerable. She had dressed as well as she could, but she was small and underweight. She had clearly not had an easy life. As with most patients who have previously experienced severe complications in the peri-viable stages of pregnancy, she was scared, perhaps even terrified that it might happen again.

Now I needed to combine dignity and compassion as I explained the risks for this pregnancy, ones that she clearly understood through previous personal experience, and the professional options for intervention open to us. Because the rate of repeat abruption in these cases is so high in this region, my institution offers admission, 6-hourly cardiotocographic monitoring and elective delivery at 34 weeks' gestation if that stage of pregnancy is reached. Should placental abruption begin in the hospital, fetal monitoring would detect it early and with the caesarean theatres being close by on the same floor, the baby and her mother should both do well. She politely declined this offer, however, as well as my offer to arrange admission to the hospital in her local town with less experienced staff. Because she was entirely reliant on unpredictable and sometimes unsafe rail transport from that town, she also declined regular return visits to my clinic, but promised instead to visit her own local clinic as regularly as she could manage. To my perplexed mind, she had chosen the bottom-ranking option. As I struggled to accept her autonomous, individualised choice, I wondered if her effort to attend my clinic had really been worthwhile and mentally reviewed my delivery of the information while documenting a careful, detailed plan in her patient-held antenatal record. At least my plan could guide her local caregivers. As I believe that counselling is more a process than an event, the final sentence of that plan read that she had been fully counselled by myself and that the doors of my clinic were open should she or her medical team wish to revise it. Disclosure, capacity, understanding and free choice constitute the essence of informed consent.[2] Although imperfect, the strength of the plan was that it was chosen voluntarily without paternalistic manipulation after clear emphasis of the real and previously experienced risks, as well as the potential benefits of inpatient surveillance in a tertiary obstetric unit. All these aspects had been properly comprehended by the patient when she made her decision. Her choice flowing from practical disempowerment had left me feeling uncomfortable, but I knew that her moral dilemma had been far greater. I had watched for emotional or non-verbal cues, realising that she had to temper her goals due to her personal social situation.

Unexpectedly, I met her again in the early morning hours of the following day, less than 24 hours after our previous meeting. I was on call, and she had been transferred by ambulance from her local town to my hospital. Her eyes were wide with fear, her skin pale, cold and clammy. Her blood pressure was low, her abdomen woody hard and her unborn baby dead. She had suffered her third consecutive catastrophic episode of placental abruption. Her condition was extremely serious, as she was in haemorrhagic shock complicated by coagulopathy, with a hard abdomen from the placental abruption combined with the previous caesarean section, a challenging case for any tertiary obstetric team and yet one that we are sadly too familiar with. Was this 'just' complete placental abruption with an intrauterine death, or had it been complicated further by rupture of the uterine scar? Meticulous care and the benefits of modern medicine allowed us to properly resuscitate our patient, safely deliver the lifeless baby vaginally and activate psychological support for a grieving mother.

On the third day I sat at her bedside reflecting on the moral dilemmas that each of us had faced. She was medically stable now, with a restored haemoglobin and platelets that were returning to normal. She was calmer too, perhaps resigned, but she had still had

no visitors. I made some extra time to talk with her for her sake and mine. I asked her if she had held her third child. She nodded as the tears welled up and showed me a small picture on her phone. I resisted the urge to cut short the moment, instead letting it linger. When she was ready, I asked her to show me a picture of her surviving daughter and her face shone as she did so. After a while, we were ready to move back to medical matters including discussions about the future. Once again, I encouraged her to stop smoking and if possible to return to my clinic for preconception counselling should she consider another pregnancy after stopping her contraceptive choice.

As I left her ward for the final time, reflection on our first encounter flooded back automatically. Could this fetal death have been prevented? From my side I had emphasised the significant risks and offered professionally acceptable intervention options, all framed within the capacity of the various institutions. From her side she had agonised between accepting the safest offer for herself and her unborn baby while considering her social responsibilities to her surviving two-year-old child with uncertain care in precarious socioeconomic circumstances. I had certainly wondered whether I had acted well and so had she. Neither of us got the outcome that we had ultimately hoped for, and yet both of us would probably have made the same decision under the same circumstances again. We were also both deeply grateful that she had come through the complication safely and could anticipate returning home to her daughter shortly. We had some things in common, but my abiding thought was that although avoiding medical paternalism is the right thing to do, it can be a painful experience.

Declaration. None.

Acknowledgements. None.

Author contributions. Sole author.

Funding. None.

Conflicts of interest. None.

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Accepted 18 April 2018.