



Neonatal Ethics Teaching Program

Problem Based Learning in Ethics (PBLE)

Antenatal Consultation at the Limit of Viability

Standardized Patient Guide

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Table of Contents

Case Scenario for Standardized Patient 3
 Description for role-playing 3
 Information to help role-playing 3
PBLE timeline 6
Instructions for the Standardized Patient..... 7

Case scenario for Standardized Patient

Clothing for role-playing: Comfortable, loose clothes (e.g. 'sweat suit'); hospital gown (provided).

Description for role-playing:

You are a 27 year old mother, pregnant at 25 weeks and 4 days gestational age. It is your second pregnancy and you have a baby boy at home who is now 3 ½ years old. Your son was born at 29 weeks gestation and was very sick with poor APGAR scores at birth and had a grade 3 intra-ventricular hemorrhage. He has cerebral palsy and is unable to walk independently. He requires equipment to help him walk. In addition, he has some language delay and a very mild cognitive delay. He is followed at the OCTC (Ottawa Children Treatment Center) for rehabilitation. You had to quit working outside of the home because of your son's handicaps and the fact that he needs a lot of support in order to help him in his development. You were working as a teacher in a high school and your husband is a lawyer in a private practice.

You came to the hospital last night because you had contractions and your water broke. You had a normal pregnancy up until now, including no hypertension or diabetes. You don't have any history of health problems. You haven't smoked or taken any medication, alcohol or drugs during this pregnancy. The fetal ultrasounds done at 7 weeks and 18 weeks were both normal without any malformation or abnormalities. You know she is a girl and you have decided on her name. Your GBS status is unknown but all your serology results from the last pregnancy were negative. You arrived in active labour but with treatment including antibiotics, magnesium sulfate, and steroids for maturation of the baby's lungs, the contractions decreased. Your baby is moving well and your cervix is dilated at 3-4 centimeters. There are no signs of fetal distress.

Because of your experience 3 ½ years ago, you know that usually the medical team resuscitates starting at around 23 weeks gestation but you are very afraid of what can happen to your baby. You and your husband discussed this and came to the conclusion that if you were going to deliver prematurely again, you would be in favour of not resuscitating before you reach 28 weeks gestation. You feel that a 15-25% risk for long-term handicaps is too much for you to take a chance resuscitating your baby; the risk of burdens on your baby and family are too high. You and your husband know that there are some other centers in Canada that accept what you are asking for.

Information to help role-playing:

1. The doctor/resident will conduct a full antenatal consultation and this should include:
 - a. Asking you what you expect from this interview.
 - b. Asking you for complementary information.
 - c. Sharing with you information about:
 - short term outcome (optional);
 - long term outcome;

- what will happen in hospital if your baby is going to be born in the next few days (optional); and
 - plan of care for your expected newborn.
2. The doctor/resident should offer you options and describe what is generally done at 25 weeks gestation and over.
 3. The doctor should ask you if you understood all information that they have shared with you.
 - You may want to ask more questions if you feel that they did not explain what would happen to your baby at birth or what they are planning to do.
 - You want to discuss what you feel are significant risks (15-25%) for long-term disabilities (including cerebral palsy, mental retardation, blindness, and deafness) and potentially could not be in the best interest of your infant.
 - You will argue with the physician that a 15-25% risk of being handicap is significant and not necessarily in the best interest of your infant.
 4. The doctor should ask you for your consent to provide care to your baby.
 - They may not give you any choice about the resuscitation. If the physician is adamant about their position of providing resuscitation, you strongly insist that you do not want any resuscitation before 28 weeks gestation because of the risks for long-term outcome and poor quality of life for your baby.
 - If they do not ask for your consent, you may say that you are the legal surrogates for your baby and you have the right to choose the care plan for your baby.
 5. At that point you will **say that you do not want any resuscitation before 28 weeks (including 27 weeks and 6 days gestation)**.
 6. If the doctor is adamant about resuscitation at 25 or 26 weeks gestation and does not want to negotiate any alternatives, you can make them feel that they could get in legal trouble by providing care without the proper consent.
 7. If the doctor wants you to accept resuscitation before 27 weeks gestation, do not accept under any circumstances.
 8. In order to help the resolution of the above conflict:
 - The doctor should be open to your position and show some respect for what you are thinking and what you want for your baby. The doctor should demonstrate some form of empathy regarding your position and try to understand your fears.
 - The doctor should try to explain to you that at a certain point or gestational age, the best interest for your baby is considered to be full resuscitation. If, as a physician, they are not providing intensive care to your baby when they think that it is most likely

in the baby's best interests, they could be in a moral dilemma and/or legal jeopardy. It is their professional duty to provide the most appropriate level of care that is considered to be in the best interests of the baby.

- You will understand the value of best interest and you may want to have more details on short term and long-term outcomes at 26 and 27 weeks gestation.
- Based on this information, you may reconsider your decision and consider agreeing with resuscitation from 26 weeks instead of 28 weeks gestation and over, but not at less than 26 weeks gestation.
- But you need to speak with your husband before giving any sort of consent for a care plan. This will leave the option for the trainee to end the discussion here and plan for a second meeting.

PBLE Timeline

Introduction (15 min)

Practice with the Standardized Patient (40 min)

- 1) 25 min to cover the initial steps of the medical encounter.
- 2) 15 min of discussion.

Practice with the Standardized Patient (40 min)

- 1) 25 min to proceed accordingly through the medical encounter.
- 2) 5 min to cover the closure of the medical encounter.
- 3) 10 min of discussion.

Conclusion (20 min)

Instructions for the Standardized Patient

1. At the beginning, you will not be introduced to the participants.
2. During the practice session with the trainees, you may be asked to leave and the scenario could be interrupted several times.
3. In the case of interruptions, the supervisor will speak with you again before resuming the session. The supervisor will advise you as to where to restart the interview and if you need to make any modifications to your role-playing.

Note:

- Repetition of certain sections is sometimes necessary for the trainees' learning experience.
 - The 'rotating' trainees may want to introduce themselves during the practice session even though they are supposed to be the same person in your eyes. Simply allow them to do so as this step makes them more comfortable.
4. At the end of the scenario, you will be introduced to the trainees and you will have to opportunity to tell them a little bit about your real self (i.e. your occupation and interests in life).
 5. You will listen to the review of the scenario's context, and then you will be asked to provide feedback about the strengths and potential areas for improvement to the trainees.

Thank you! We really appreciate your participation and valuable feedback!