# SCENARIO 2 - Consultant Obstetrician (Part 1)

## Content warning

Please be aware the following scenario centres on the decision of a pregnant patient not to follow medical advice, the consequences of which could be harmful to patient and fetus, and the emotional and moral harm this causes for staff. Please consider your potential emotional responses to these topics before engaging with this scenario and related discussions.

## Context

Since childhood the consultant obstetrician has been committed to a career in medicine. They are the first doctor in the family, with parents and siblings very proud of their role and achievements. Being part of a large family, they helped with raising their siblings, which led to a particular interest in maternity care and new life. In training, they sought exposure to specialities that interacted with pregnancy, childbirth, and early childhood, and chose to specialise in Obstetrics, qualifying as a consultant 4 years ago. They like having a role in bringing new life into the world, even when a birth might be more complex. The role is varied and requires facing new challenges every day.

## Scenario

The Consultant is engaged in a routine outpatient clinic. Due to staff sickness, the clinic is overbooked and unusually busy. This puts pressure on the consultant not to overrun and create knock-on effects for patients and wider staff.

At this clinic, the Consultant sees a patient with a significant cardiac condition that was diagnosed in their first pregnancy. While they had successfully given birth to a healthy baby by c-section, the patient had been given medical advice not to become pregnant again due to the risk posed by pregnancy of death and/or a permanent, serious deterioration in their cardiac condition. Despite this advice, the patient is 16 weeks pregnant. Both the patient and their partner are happy about the pregnancy, the pregnancy is very much welcomed and the baby very much wanted. Given the prior history and medical advice, the Consultant strongly advised a referral to the cardiac team, sharing ongoing care with that team, with an early elective delivery by c-section.

The patient believes everything will be okay if they slow down and take special care of themselves, as things turned out fine last time. They are unhappy about the multi-disciplinary approach and want everything to be as “normal” as possible, including a vaginal delivery. The Consultant considers that this is unrealistic and is very concerned about the risks the patient is taking for themselves and their baby. However, due to the

pressure of time, the Consultant provides the patient with some leaflets to read and arranges a consultation the following week to discuss the patient's care further.

At the next appointment, the patient remains adamant that they are not willing to consider involving cardiology or an early delivery by c-section. The patient continues to be seen regularly in the consultant-led antenatal clinic. At 30-weeks pregnant, the patient's decision regarding antenatal care plan is unchanged. The patient has, however, agreed to be admitted to the hospital for close monitoring. The Consultant is also concerned that the foetus is small for dates and not developing as expected. A second opinion from another consultant obstetrician has been offered to the patient but was declined.

The Consultant is at a loss about what to do to change the patient's mind about early delivery by c-section. They have been feeling fearful and helpless, believing that a preventable tragedy is about to unfold, despite their best efforts to prevent it. They feel very much alone in facing this challenging situation. They have spoken to another consultant colleague whose response was that 'this is just part of the job', telling them to 'move on' from worrying about it. The Consultant feels there is an expectation that senior doctors be 'stoic', that they show no emotion. This is in complete contrast to the inner turmoil the Consultant is experiencing. They also feel let down by their clinical director, who seems only to view the situation as a delicate legal matter - legal advice has been received to maintain careful records about information provided to the patient, their level of understanding of this information, etc.

An MDT meeting was organised to discuss the case when the patients was around 25 weeks pregnant. The meeting started late, and the discussion was very rushed because people needed to finish on time and to dash off to other commitments. The conclusion from the meeting seemed to be that because the patient was fully competent and was adamant in their refusal to consent to an early c-section, there was nothing to be done but hope the patient changed their mind. Despite recognising that everyone was busy and under pressure, the Consultant felt there had been inadequate discussion of the case. While they understood that it wasn't their colleagues' fault there was no time for a fuller discussion, the Consultant couldn't help feeling let down and completely alone in navigating this complex clinical situation.

As a result of this case the Consultant has begun to question their abilities as a doctor and an obstetrician. They can't help thinking that, had the patient had seen another consultant - any other consultant - the outcome might be different. The Consultant has lost the sense of satisfaction they usually get from doing their job. They are sleeping badly, and have developed imposter syndrome, which is eroding their confidence further. They are going to work every day terrified of learning that the patient and/or the foetus has died, and that it will all be their fault.