ResetEthics
THE MORAL HARM PROJECT

SCENARIO 2 - Consultant Obstetrician (Part 2)

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 medical career. 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 had helped with raising their siblings, leading to a particular interest in maternity care and new life. They have sought training exposure to specialities that interacted with pregnancy, childbirth, and early. childhood, and had chosen 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 the arrival might be more complex. The role is varied and requires them to face new challenges every day.

Scenario

In a routine outpatient clinic, the Consultant had seen a patient with a significant cardiac condition that had been diagnosed in their first pregnancy. Following the successful birth of a healthy baby by c-section, the patient had been given medical advice not to become pregnant again due to the risk of death and/or risk of permanent, serious deterioration in their cardiac condition posed by pregnancy. Despite this advice, the patient was 16 weeks pregnant when she first sees the Consultant. Both the patient and their partner are very happy about the pregnancy. Given the prior history and medical advice, the Consultant strongly advised a multi-disciplinary approach to care, with an early elective delivery by c-section. The patient is unhappy about the multi-disciplinary approach and wants everything to be as “normal” as possible, including a vaginal delivery. The Consultant considers this unrealistic and is very concerned about the risks the patient is taking for themselves and their baby. The patient continues to be seen regularly in the consultant-led clinic, and at 30 weeks, their decision regarding care remains unchanged. This is despite having been seen by a consultant cardiologist because their heart condition is already worsening. The patient has agreed to be admitted to the hospital for close monitoring.

The Consultant continues to feel worried and upset about this case, never having previously had a patient facing such a serious medical outcome for themselves, the fetus and the rest of their family and resolutely refusing all medical advice. The situation has caused the Consultant to lose confidence and feel imposter syndrome taking hold. They continue to try and portray themselves as stoically accepting patient-informed choice, whilst at the time ensuring meticulous record keeping, as advised by the legal team. This outward display is in complete contrast to how they are feeling internally. They feel very upset, and that they are failing - if not the patient, then the fetus, which remains small-for-dates at 30 weeks, and is not developing as expected.

Following the rushed MDT meeting where the case was discussed, and with the patient really preying on the Consultant's mind, they decided to speak to a different, more senior colleague than they had consulted previously. This colleague was great, they really made time to listen and validate the concerns and sense of personal responsibility the Consultant was feeling. They had already heard about the case, but not in any great detail, and offered to review the case notes with the Consultant the following day. The Consultant found this really useful, providing an opportunity to talk through the professional ethical difficulties arising at each stage of caring for this patient. The colleague understood the Consultant's sense of responsibility, fears for the patient and the fetus, and sense of professional and legal responsibilities and repercussions. The colleague helped the Consultant to recognise that they were experiencing moral harm due to the difficulties of the situation, and that it was important to make time to consider the impact moral harm was having on the Consultant's professional sense of self, and emotional wellbeing.

The colleague also suggested asking the Trust's clinical ethics committee for consultation, explaining that they could offer their perspective on the ethical tensions so that their advice could be taken to the next MDT meeting. The Consultant agreed that hearing what others not so closely involved in the patients care thought would be helpful. The discussion with the clinical ethics committee was very helpful. They obviously weren't there to say what to do, but they really understood the ethical difficulties given the patient with an adult with capacity. They helped to formulate the ethical tensions to take to the next MDT meeting, and there was a focus on how all of those involved would be supported should the patient not change her mind, and clinicians' worst fears materialise.

At the next MDT meeting others, including the midwives, expressed their unease about the situation, leading the Consultant to feel that the ethical responsibility was now being shared with others. There was a sense that all avenues were being explored, and whilst the Obstetrics team were unable to change what was happening, it did help the Consultant to feel there was now a sense of all being 'in it together'. There was agreement amongst the Obstetrics team to present the case at a grand round, foregrounding the ethical issues the team had encountered, and to arrange ethics

training on managing conflicts of interest in pregnancy and labour. The Trust agreed to fund a clinical ethics specialist to run the training day, and the junior doctors in the team rated the session very highly, feeling it had helped to prepare them for the responsibilities they may carry in the future. Lastly, there was agreement that once events had played out, whatever the outcome, they would plan for an appropriately-timed a Schwartz round to ensure all on the staff team felt heard and supported through a difficult experience. In the interim, a facilitated reflective psychological debrief was also requested to help respond to the current strength of feeling among staff in relation to this case.

Overall, the Consultant felt they learned several things from this experience. The first was that if they didn't feel supported by one colleague, this doesn't mean there is something wrong with them – that they aren't 'up to the job' - or that no support is available. Second, they had come away with a better understanding of the centrality of ethics to some of the decisions obstetric consultants need to make and have since undertaken further clinical ethics courses to deepen this understanding. This has led to being much clearer about what they are responsible for, and what is completely beyond their control and therefore responsibility. Finally, they have a much better sense of how best to support others to recognise moral harm and respond to what they are experiencing. They feel that the team is stronger because of how they came together to tackle this challenging situation. The directorate manager also came through for the team by providing a relatively small amount of money to support requests for training and specialist support.