Perivable Ethics
September 6th

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University of Colorado MFM

NO DISCLOSURES OR CONFLICTS OF INTEREST

Goals
Discuss pertinent ethical issues pertaining to
– Medical decision making at the threshold of viability
– Provider bias/conscientious objection to treatment plan
– Informed consent in a pregnant minor
Four Topics
Medical Indications
• How can the patient be benefited from medical care?
• How can harm be avoided?

Patient Preferences
• How to respect autonomy?
• How to determine capacity?

Quality of Life
• What is a reasonable life outcome for the patient given treatment versus no treatment?
• How do you judge quality of life? What biases exist?

Contextual Features
• Societal, legal, institutional, financial, religious, public health considerations

World’s Smallest Surviving Baby Finally Goes Home from San Diego Hospital: ‘She’s a Miracle’
“At 254 grams, there’s reservations on survival”
“But despite the low odds, the nurses and Saybie’s parents kept fighting for her”
“She’s a miracle, that’s for sure”

Case
• 15 yo at 23w1d (9) transferred to UCH for vaginal spotting with low-lying placenta.
  - Pregnancy complicated by IUGR, EFW 247 g (<2%).
  - Normal UA Dopplers, evidence of brain sparing, absent DA A-wave
  - Negative IUGR work-up
  - Admitted for monitoring of vaginal bleeding

• Multidisciplinary meeting with family, NICU and MFM

• “She reports this was an unplanned pregnancy but very strongly desires to continue.”
Review Medical Indications

- 1. Acute (vaginal bleeding), possibly reversible
- 3, 4, 5 - requires further discussion.
When is medical treatment NOT indicated

1) If the fetus is not a patient
   - Becomes a patient when presented to healthcare profession and there are clinical interventions reliably expected to benefit that human being
   - Solely as a function of the pregnant women’s decision to confer this status on her fetus.
   - Viable fetuses become patients with presentation for OB care

2) If the fetus is not viable


What is periviability?

• Medically defined as 20 0/7 weeks to 25 6/7 weeks
• Viability
  “Sufficient maturity they can survive into neonatal period given the availability of the requisite technological and clinical support.”
• Variable in different parts of the world based on level and accessibility of perinatal care.
• Increased survival, but long-term neurodevelopmental outcomes have not improved
• These births present significant emotional and financial burdens to families and the healthcare system

What are the probabilities of success of various treatment options?
Overall VLBW survival - 91%, VON average 89%

Survival rate last 15 years (for babies that received DR resuscitation and NICU care):
- 23 weeks - 72%, VON average 53%
- 24 weeks - 73%, VON average 68%
- 25 weeks - 78%, VON average 79%
- 26 weeks - 91%, VON average 86%

Beyond 26 weeks, >90% survival and depends more on pregnancy than gestational age.

Long term neonatal outcomes
Across this range of gestational ages, there is an additional proportion of burdened survivors with lesser degrees of disability.

### University of Iowa Protocol

- Protocol approach for 22-24 weeks gestation
- Separate NICU wing
- Includes fluids, transfusion guidelines, phototherapy, ventilation goals, respiratory settings, feeding guidelines, Abx, etc.
ACOG Consensus Statement on Periviable Birth, 2017

**NICU consult**

- “We would be unable to offer resuscitation at this time given her gestational age (23w1d) and severity of growth restriction (247g)”

- “Based on a variety of clinical variables and interventions that are possible in significantly growth restricted infants, we would recommend beginning to monitor once the fetal weight is estimated closer to 350g”

**Case**

- Vaginal spotting monitored x 2 days, discharged to home

- Viability check in 1 week w local provider

- Growth/ECHO in 2 weeks in Denver
4 days later-Viability Check

- 24w0d, per referring provider’s discretion, EFW 330 g (83 g increase in 4 days)
- AEDF on Dopplers

“Extensive counseling with NICU regarding periviable delivery, that baby’s EFW pushes physical limits of resuscitation.”

“PL, FOC and family all desire most aggressive resuscitation possible.”

“They were amenable for plan to start monitoring after BMZ complete.”

Preferences of Patients

1. Has the patient been informed of benefits and risks of diagnostic and treatment recommendations, understand this information, and given consent?
2. Is the patient mentally capable and legally competent or is there evidence of incapacity?
3. If mentally capable, what preferences about treatment is the patient stating?
4. If incapacitated, has the patient expressed prior preferences?
5. Who is the appropriate surrogate to make decisions for an incapacitated patient? What standards should govern the surrogate’s decisions?
6. Is the patient unwilling or unable to cooperate with medical treatment? If so, why?

Preferences of Patients

1. Prior counseling multidisciplinary. Resuscitation not previously on the table. Now a possibility with EFW and GA.
2-6 requires further discussion
In which scenario(s) would you allow a 15 year old patient to consent independently?

- Birth control
- STD testing
- Cesarean delivery
- Abortion
- None of the above
- All of the above

Consent of a minor

Prenatal, Delivery, and Post-Delivery Medical Care


Q: Does a teen become emancipated upon her or she becomes a parent, or once she becomes pregnant?

A: No. Becoming pregnant or a parent does NOT emancipate a minor in Colorado. A pregnant or parenting teen remains a minor in the eyes of the law. In order to consent for her or her own health care, a pregnant or parenting teen must meet one of the minor consent's exceptions described in the mini-lesson "Colorado Minor
Consent Laws" also in this toolkit. (For example, any teen, including a pregnant or parenting teen, may consent for his or her own health care if he/she is 15 or older, living separately from his or her parents or guardian, and managing his or her own financial affairs.)

Understanding Minor Consent and Confidentiality in Colorado: An Adolescent Provider Toolkit; www.cde.state.co.us

Capacity

- Understanding of relevant medical information
- Understanding of the risks of not completing the proposed medical intervention
- Understanding the risks of the proposed medical intervention
- Understanding treatment alternatives
Preferences of Patients

2. Patient is mentally capable and legally competent

3. Patient states preference for full resuscitation

4 – 6 N/A.
Case
- Monitored inpatient, twice daily NSTs
- @25w4d, NST with minimal variability, recurrent spontaneous decelerations
  - Updated bedside biometry, **EFW 271 g**
- Conference with NICU, MFM, OB Hospitalists

What would you do as a patient?
- Request full intervention including cesarean delivery
- Request expectant management
- Request termination of pregnancy

UCH Poll (MFM/OB/NICU/Residents)

<table>
<thead>
<tr>
<th>What would you do as a patient?</th>
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<tbody>
<tr>
<td>Request full intervention including cesarean delivery</td>
</tr>
<tr>
<td>Request expectant management</td>
</tr>
</tbody>
</table>
What would you do as a provider?

- Strongly recommend cesarean
- Offer cesarean
- Strongly discourage cesarean, but still offer
- Not offer cesarean
- Recommend termination of pregnancy

UCH Poll (MFM/OB/NICU/Residents)

What would you do as a provider?

- A. Strongly recommend cesarean
- B. Offer cesarean
- C. Strongly discourage cesarean, but still offer (71%)
- D. Not offer cesarean (29%)
- E. Recommend termination of pregnancy

What about provider autonomy?
Maternal request for C/S in Periviable fetus

“A physician might believe that maternal risks of surgery are determinative since neonatal benefits from such an intervention would be de minimis. Hence, they might reject all requests for surgery since no good could obtain to the fetus, and the mother's risks might be consequential.”


1. No treatment: Fetal- Death Delivery: Maternal- Morbidity

2. IUGR babies MAY have morbidity (NEC, hypoxic brain injury w/ sequelae, need for respiratory support, lung injury, ROP) and mortality; but MAY not.

3. Further discussion

4-6 N/A.

Provider bias

Patients

• Physicians reports of morbidity and death NOT central to decision-making

• Religion, spirituality and hope guided most parents

"Left things in god's hands"

Providers

"patient wants everything done"
Provider Bias

“When physicians consider neonatal death and life with a severe disability, the former is often perceived to be the ‘least worst’ outcome”

“Death of a neonate at 23 weeks might not be considered by many to be the most ‘disastrous’ outcome for a family, for society or even for the fetus itself. Some might consider survival of a neonate condemned to a lifetime of severe disability, blindness, deafness, severe motor and cognitive impairment even more ruinous.”


Maternal health outcomes

• Uterine rupture (OR 4.5)
  – Regardless of type of hysterotomy

• Future preterm birth (35.9 w vs. 36.9 w)

• Future low birth weight (2736 g vs. 3014 g)

• Perinatal PTSD


“Physicians’ values are also part of counseling, but they are appropriately considered only when they are medical values (beneficence, truth telling, not personal beliefs (e.g., children with impairments should have, or not have, a ‘do not resuscitate’ order).

Physicians have the right to refuse to participate if they think that the biologic risk overwhelms a potential value-based benefit, but they should be loath to do so if the balance is anywhere close to equipoise, and the patient’s values are deeply held.”

Provider Autonomy

When a patient makes a choice, a physician should honor that decision, unless it is unethical or futile.

Positive Patient Autonomy

- Autonomy
  - Positive vs. negative (right to refuse treatment)
- Futility
  1. There is a goal.
  2. There is an action and activity aimed at achieving this goal.
  3. There is virtual certainty that the action will fail in achieving this goal.
- What is the goal?
  - Survival?
  - Intact survival?
  - Avoiding classical hysterotomy?
Survey

- Factors related to BMZ administration
  - Institutional cutoff 23 weeks 4 x more likely to give BMZ
  - Providers' personal preferences for periviable CD
    - Desiring CD at 25 weeks 3 x less likely to offer BMZ at 23 weeks than CD at 24 weeks (OR=0.30, 95% CI=0.13 to 0.70).

Survey

- Some evidence of immediate survival > VLBW breech babies by C/S
- No difference in long-term survival or neurodevelopment impairment for cesarean-born neonates.
- Nevertheless, a previous study of MFM found that, even when they do not think there is evidence to support the decision, many OBs still feel inclined to perform CD.
Justice

1. Provider bias/provider autonomy.
2. Family desired full resuscitation attempts
3-5. N/A
6. See next
7. N/A

Case

“She has remained steadfast in her desire for maximal neonatal resuscitation throughout her clinical course and understands the limitations that extreme low birthweight may put on resuscitation for her baby.”

When patients take on biologic risks in order to achieve spiritual gain, physicians may be less comfortable accepting the patient's choice than when the patient chooses the clinical path posing the least biologic peril.
Shared Decision-Making

<table>
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<th>Table 1: Benefits of decision-making described in prenatal care encounters</th>
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<tr>
<td>Fighting Chance</td>
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<tr>
<td>Best interest, pain, suffering</td>
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<tr>
<td>Disability</td>
</tr>
<tr>
<td>Faith in a higher power</td>
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Fighting Chance

Best interest, pain, suffering

Disability

Faith in a higher power

Case
– Patient continued to desire full resuscitation
– Delivery via transfundal classical hysterotomy
– Birthweight 285 g, APGAR 5/6/6

Case
• Neonate successfully intubated with 2.0 ETT at 21 minutes of life
• DOL 1
  – OG placement with concern for esophageal perforation
  – Maximal respiratory and vasopressor support
• DOL 2
  – Continued desaturation and hypotensive events
  – Family elected to withdraw support

When would you offer neonatal resuscitation (Take 2)?

<table>
<thead>
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<th>Option</th>
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<tr>
<td>250 grams</td>
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<tr>
<td>300 grams</td>
</tr>
<tr>
<td>500 grams</td>
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<tr>
<td>Any pregnancy &gt; 22 weeks</td>
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<tr>
<td>Any pregnancy &gt; 23 weeks</td>
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<tr>
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Take home points

- Survival outcomes at the threshold of viability are complex
  - Affected by many factors
  - Patients/providers may have divergent views on the "goal" and "futility"
- Shared decision-making between patients and providers is necessary in cases of periviability
  - Personal and institutional biases in counseling
- Minors can consent for prenatal, delivery and postpartum care in Colorado
- Ethically justifiable outcomes may not be in line with providers personal beliefs.

Questions?
Ethical dimensions of periviability

Article in Journal of Perinatal Medicine · November 2010
DOI: 10.1515/JPM.2010.098 · Source: PubMed

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A statement of the World Association of Perinatal Medicine

Ethical dimensions of periviability

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Abstract

The birth of neonates at the limits of viability, or periviability, poses numerous challenges to health care providers and to systems of care, and the care of these pregnancies and neonates is fraught with ethical controversies. This statement summarizes the ethical principles involved in the care of perivable pregnancies and neonates, and provides expert clinical opinion about the numerous challenges posed by this problem around the world. Topics addressed include a summary of the published experience, an ethical framework, translating neonatal outcome data to the obstetric arena, management as a trial of intervention, referral to tertiary centers, neonatal resuscitation, cesarean delivery for fetal indication, and limits on life-sustaining neonatal treatment.

Keywords: Extreme prematurity; extremely low birth weight; limit of viability; periviability; premature birth; premature labor.

Introduction

The latter half of the 20th century brought enormous changes in the care of premature neonates. The cusp of viability, where some but not all infants may be able to survive, has been pushed to incrementally lower gestational ages. The number of neonates born yearly at extremely premature gestational ages has increased dramatically. Despite the dramatic improvements in neonatal survival, our ability to prevent prematurity does not appear to have changed. Periviability (22–24 weeks’ of gestation) has generated ongoing clinical
Published experience

The derivation of best practices for the setting of periviability is incumbent upon accurate data on the survival and morbidity of neonates at these gestational ages, taking into account the accuracy of gestational dating, the birth weight, the clinical settings that lead to a likelihood of delivery in the perivable time [e.g., preterm premature rupture of the membranes (PPROM), fetal anomalies, preterm labor, cervical insufficiency], and the outcome data on the efficacy of interventions in a specific center, area or country. Using such information allows an approach to the decision-making and treatment of the perivable fetus and neonate that is “evidence-based.” Survival and morbidities of perivable neonates in tertiary centers have been described [9]. Neonates born at centers of excellence are reported to have outcomes that are better than neonates included in geographically based studies [6]. The degree of improvement in survival at tertiary centers for neonates born before 25 weeks’ gestation is the equivalent to being born 1 week later at a non-tertiary center.

Recent publications from individual centers and collaborations of centers have described the outcomes of perivable neonates – the EPICure collaboration, the MOSAIC collaboration and the United States National Institute for Child Health and Human Development (NICHD), Neonatal Research Network (NRN) [8, 10, 12, 13, 16, 23]. These publications from tertiary center collaborations show that:

- Below 22 weeks’ gestational age, there is no survival.
- At 22 weeks, survival ranges from 1 to 15% and survival without profound disability ranges from 2 to 13%.
- At 23 weeks, survival ranges from 8 to 33% and survival without profound disability ranges from 7 to 23%.
- At 24 weeks, survival ranges from 26 to 51% and survival without profound disability ranges from 12 to 38%.
- Across this range of gestational ages, there is an additional proportion of burdened survivors with lesser degrees of disability.

These data are informative in counseling parents before and after the birth of an extremely premature neonate, particularly regarding the advisability of resuscitation immediately after birth or the continuation of neonatal critical care to sustain life thereafter.

The landmark paper by Tyson et al., and the NICHD enables more precise prognostic judgments for neonates than those based on gestational age alone. An algorithm is available at a website that allows neonatologists to enter five clinical factors and receive immediately a calculation regarding the likelihood of survival and survival without profound or moderate disability [22]. Unfortunately, this algorithm has not been shown to be applicable in an obstetric population [21]. This website is entitled “NICHD NRN Extremely Pre-term Birth Outcome Data,” and is available at http://www.nichd.nih.gov/about/org/cdbpm/pp/prog_epbo/epbo_case.cfm.

Ethical framework

Four ethical concepts play a central role in perinatal ethics:

- Beneficence is the ethical principle that requires physicians to seek, on balance, a greater amount of clinical good than harm for the patient [4, 14].
- Respect for autonomy is the ethical principle that requires physicians to empower patient autonomy by providing information needed for informed consent and to implement the competent patient’s decisions about management unless there is a compelling beneficence-based objection [4, 14].
- Justice is the ethical principle that requires fairness in the allocation of limited resources [4]. Procedural justice requires that all affected individuals be taken into account. Substantive justice requires that exploitation is prevented. Exploitation occurs when a small percent of a population of patients experiences a clinical benefit, such as survival with little or no clinical harm of morbidity and disability, while a very large percent of the population of patients experiences the clinical harms of either mortality, serious morbidity, or serious disability [5].
- A human being becomes a patient when that human being is presented to a physician or other healthcare professional and there exist clinical interventions reliably expected to benefit that human being clinically. Preivable fetuses become patients solely as a function of the pregnant woman’s decision to confer this status on her fetus(es). Viable fetuses become patients when the pregnant patient presents for obstetric care [14].

- Fetuses are viable when they are of sufficient maturity that they can survive into the neonatal period given the availability of the requisite technological and clinical support. Viability is thus variable in different parts of the world, depending on the level of and accessibility to perinatal care.

A pregnant woman’s relationship with her fetus is the most intimate in all human experience. Therefore, perinatal ethics
Referral to tertiary centers

• The data supporting better outcomes at centers of excellence (MOSAIC, EPICure) suggest that the fetuses of women with perivable pregnancies who are likely to deliver soon may benefit from referral to tertiary centers.
• Referral to tertiary centers before birth should be encouraged, if delivery is not imminent.

Neonatal resuscitation

Resuscitation of perivable neonates immediately after birth is technically challenging and not always successful [1].

• At 22 weeks’ of gestation and earlier with gestational dating that is secure, imminent death cannot be prevented by any means. There is therefore no beneficence-based obligation to offer neonatal resuscitation and if requested, resuscitation should be denied [6].
• At 24 weeks and after, without severe fetal anomalies and without severe fetal growth restriction, the short-term goal of preventing imminent death is possible and there is a reasonable probability of achieving the long-term goal of producing minimal morbidity and maximal functional status. These outcomes mean that there is a beneficence-based obligation to intervene. Immediate neonatal resuscitation should therefore be instituted, for which parental authorization should be sought [2, 6]. Severe fetal anomalies are those that are incompatible with life or those that lead to an irreversible loss of the capacity to interact with the environment [6].
• At 23 weeks, with gestational dating that is secure, the outcomes do not clearly show a greater balance of clinical goods over harms, and may involve the opposite. Although resuscitation may prevent imminent death in a small percentage of cases, death occurs more frequently than survival and among survivors serious morbidity and disability occur more often than intact survival. Because routine resuscitation would result in exploitation, immediate neonatal resuscitation is not required [6].

The lack of appropriate long-term follow-up care in some resource-poor areas is a factor that is optimally included in the decision about resuscitation immediately after birth in the perivable gestational age range. For those infants who survive with significant disabilities the availability of palliative care is not widespread. Greater allocation of health care resources to improve this situation is necessary [7].

Cesarean delivery for fetal indication

• At 22 weeks’ of gestation and earlier with gestational dating that is secure, imminent death cannot be prevented by any means. There is therefore no beneficence-based obligation to offer cesarean delivery, even in the presence of...

Translating neonatal outcome data to the obstetric arena

Algorithms that use neonatal outcome data to predict survival and morbidity for neonates, such as the one described above from the NICHD NRN, are an important step forward for neonatal management decisions.

• The use of these algorithms for predicting outcomes for perivable fetuses (i.e., before birth) is fraught with difficulty and is not recommended.
• This results from increased and inherent uncertainties present before birth, when the factors that help to predict outcomes are not known with certainty [21].
• Prospective testing of such algorithms (derived from neonatal outcome data) in the setting before birth to determine their accuracy is necessary.

Trial of intervention

Management of life-threatening conditions, such as periviability should be understood as a trial of intervention. Such a trial has two goals.

• The short-term goal is to prevent imminent death.
• The long-term goal is to minimize morbidity and maximize functional status.
• Clinical intervention should be initiated and continued only so long as these goals are reasonably expected to be accomplished [6].
• For the fetus or neonate at 22 weeks’ of gestation and earlier, when gestational dating is secure, the short-term goal of preventing imminent death cannot usually be achieved by any means, including resuscitation, cesarean delivery, and neonatal intensive care.
• At 22 weeks’ of gestation or earlier, when gestational dating is secure, cesarean delivery should not be offered, and should be denied if requested, because the woman will undergo the clinical risks of surgery with no potential for clinical benefit for the fetal or neonatal patient.
a fetal indication, e.g., acute fetal distress. If cesarean delivery is requested, it should be denied [6].

- At 24 weeks and after, without severe fetal anomalies and without severe fetal growth restriction, cesarean delivery for fetal indication should be offered and recommended.
- At 23 weeks, in the absence of a fetal indication there is no conclusive evidence suggesting a benefit to the fetus/neonate of cesarean delivery [20]. Cesarean delivery in the absence of a fetal indication should not be offered and if requested should be denied. In the presence of a fetal indication cesarean delivery may be offered if neonatal resuscitation is planned after birth.

**Limits on life-sustaining neonatal treatment**

Neonatal life-sustaining treatment can reach its ethical limits when the likelihood of achieving either the short-term or long-term goal of a trial of management becomes very small (i.e., further treatment becomes futile) and the risk of unacceptable burdensome morbidity and disability caused by continued intervention rises to a level at which the physician’s fiduciary relationship with the infant requires that a discontinuation of intensive medical support be considered [11].

This is especially the case when the patient has irreversibly lost the capacity to interact with the environment [6]. In this setting, offering parents the alternative of discontinuing life-sustaining treatments becomes ethically acceptable, as is the palliative use of pharmacologic therapies that may, as an idea, at least briefly, of what might be expected thereafter. “Thereafter” includes the process of delivery, the process of neonatal resuscitation (if required), the process of dying (if this occurs), and the continued life of an infant with additional morbidities (if these occur). Involving the appropriate medical and surgical specialists as well as spiritual counselors should also be considered.

An unfortunate reality is that many developed countries have resources that allow healthcare systems to produce the outcomes seen above, but in other areas of the world these resources are scarce and are diverted to other areas. This leads to different outcomes that may change the gestational ages at which the above ethical principles operate. The balance that may help decide when initial attempts at aggressive care are appropriate is likely to shift to later gestational ages in resource-poor areas. Lastly, an important task for the future is focusing efforts on the prevention of prematurity so that the difficult decisions of the situation of periviability occur less often.

**The art of perinatal medicine**

The perinatal physician has beneficence-based obligations to the fetal patient that must be balanced carefully against the perinatal physician’s beneficence-based, fiduciary, and autonomy-based obligations to the pregnant patient. This balancing should guide and coordinate perinatologists, neonatologists, and other healthcare specialists in all cases [18, 19]. The unique psychosocial aspects of each case should be taken into account. Because the accuracy of prognosis in the perivable period is weak, how the decision-making process is conducted is critically important [15]. Every infant is different and should be considered individually. Perinatal clinical decision-making must often occur with a certain degree of uncertainty. Factors beyond standardized assessments may influence infant outcomes. The principles mentioned herein should be interpreted as general principles which need to be adapted to each individual situation. The wishes of the parents or the mother are particularly important and should be included in all discussions about management, both before and after birth [2]. Counseling the parents is extremely important. Optimal counseling involves obstetric and neonatal care providers in concert, and includes providing the statistical probability of survival or death if this is available, the statistical probability of neurodevelopmental impairment, as well as some idea, at least briefly, of what might be expected thereafter. “Thereafter” includes the process of delivery, the process of neonatal resuscitation (if required), the process of dying (if this occurs), and the continued life of an infant with additional morbidities (if these occur). Involving the appropriate medical and surgical specialists as well as spiritual counselors should also be considered.

**References**


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## The Four Topics Chart

<table>
<thead>
<tr>
<th>Medical Indications</th>
<th>Patient Preferences</th>
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<tbody>
<tr>
<td>The Principles of Beneficence and Nonmaleficence</td>
<td>The Principle of Respect for Autonomy</td>
</tr>
<tr>
<td>1. What is the patient’s medical problem?</td>
<td>1. Has the patient been informed of benefits and risks, understood this information, and given consent?</td>
</tr>
<tr>
<td>2. What are the goals of treatment?</td>
<td>3. If mentally capable, what preferences about treatment is the patient stating?</td>
</tr>
<tr>
<td>3. In what circumstances are medical treatments not indicated?</td>
<td>4. If incapacitated, has the patient expressed prior preferences?</td>
</tr>
<tr>
<td>4. What are the probabilities of success of various treatment options?</td>
<td>5. Who is the appropriate surrogate to make decisions for the incapacitated patient?</td>
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<tr>
<td>5. In sum, how can this patient be benefited by medical and nursing care, and how can harm be avoided?</td>
<td>6. Is the patient unwilling or unable to cooperate with medical treatment? If so, why?</td>
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## Quality of Life

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<tbody>
<tr>
<td>The Principles of Beneficence and Nonmaleficence and Respect for Autonomy</td>
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<tr>
<td>1. What are the prospects, with or without treatment, for a return to normal life, and what physical, mental, and social deficits might the patient experience even if treatment succeeds?</td>
</tr>
<tr>
<td>2. On what grounds can anyone judge that some quality of life would be undesirable for a patient who cannot make or express such a judgment?</td>
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<tr>
<td>3. Are there biases that might prejudice the provider’s evaluation of the patient’s quality of life?</td>
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<tr>
<td>4. What ethical issues arise concerning improving or enhancing a patient’s quality of life?</td>
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<tr>
<td>5. Do quality-of-life assessments raise any questions regarding changes in treatment plans, such as forgoing life-sustaining treatment?</td>
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<tr>
<td>6. What are plans and rationale to forgo life-sustaining treatment?</td>
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<td>7. What is the legal and ethical status of suicide?</td>
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</tbody>
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<table>
<thead>
<tr>
<th>The Principles of Justice and Fairness</th>
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<tbody>
<tr>
<td>1. Are there professional, interprofessional, or business interests that might create conflicts of interest in the clinical treatment of patients?</td>
</tr>
<tr>
<td>2. Are there parties other than clinicians and patients, such as family members, who have an interest in clinical decisions?</td>
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<tr>
<td>3. What are the limits imposed on patient confidentiality by the legitimate interests of third parties?</td>
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<tr>
<td>4. Are there financial factors that create conflicts of interest in clinical decisions?</td>
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<tr>
<td>5. Are there problems of allocation of scarce health resources that might affect clinical decisions?</td>
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<td>6. Are there religious issues that might influence clinical decisions?</td>
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<td>7. What are the legal issues that might affect clinical decisions?</td>
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<tr>
<td>8. Are there considerations of clinical research and education that might affect clinical decisions?</td>
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<tr>
<td>9. Are there issues of public health and safety that affect clinical decisions?</td>
</tr>
<tr>
<td>10. Are there conflicts of interest within institutions and organizations (e.g., hospitals) that may affect clinical decisions and patient welfare?</td>
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