AIMS For a better birth...

Whoops!

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The following story illustrates - yet again - the risks pregnant women run when seen in Accident & Emergency departments by junior doctors whose confident diagnoses conceal their ignorance of obstetrics and gynaecology.

Recently, a story[1], from Coventry, emerged as a fascinating example of, among other things, the ethical blind spot so common in doctors involved in obstetrics, who seem to have no idea of what 'informed consent' really means.

A 16-year-old arrived in the A & E complaining of abdominal pain and vaginal bleeding after three months without periods, as well as nausea and vomiting. The Senior House Officer (SHO, in other words, a medical student) examined her, diagnosed a miscarriage after a 12-week pregnancy, and referred her to the operating theatre for ERPC (evacuation of retained products of conception).

Only after she had been anaesthetised, two hours later, did a gynaecology SHO notice that the young woman's tummy looked more like a full-term pregnancy. She called the registrar, who confirmed it, and found a fetal heartbeat with the Doppler. The doctor commented, "We could not proceed with a caesarean section because of lack of consent." They tried to find the teenager's mother to give consent, but were unable to do so. So they decided to wake her up and send her to the labour ward (a 15-minute trolley drive away). Although she was found not to be fully dilated in the recovery room, a 30- to 32-week baby, with an Apgar score of 8, was born within five minutes of her arriving in the delivery suite. The infant was sent to the special-care baby unit, but needed no intervention and is doing well.

The authors point out that the young woman had not been seen by a senior gynaecologist before being sent off for ERPC -and that most gynaecologists do not insist on a scan before doing one. The Confidential Enquiry into Maternal Deaths 1994-6 recommended that: "all women should undergo ultrasound before termination of pregnancy to establish gestational age, viability and site". They also say that it was fortunate that the young mother also gave a history of nausea and vomiting because they had intubated her to ensure an airway-otherwise, if she had regurgitated, she could have choked (general anaesthesia can be more risky in women in advanced pregnancy).

The letter provoked a response from a doctor in Belfast[2], who suggested that, as well as failing to do an ultrasound in the A & E, the junior doctor had probably failed to expose and examine the abdomen and that, too, should be investigated. He suggests, however, that waking the woman up to deliver the baby might not be best care. General anaesthesia itself is associated with premature labour-indeed, she gave

birth 20 minutes after having the anaesthetic and, if the delivery suite had been further away, she could have had the baby in the corridor. Also, if the cause of bleeding had not been identified, there could have been placenta praevia or abruption, in which case, a caesarean would have been safer.

Quite rightly, though, he also pointed out that a mother could not consent for a daughter who was 16 and competent - but the problem would never have arisen if she had been properly assessed in the first place. And, in any case, there was no immediate need for intervention; the 'miscarriage' could have been managed expectantly.

Then, doctors from Birmingham chimed in[3], reminding Coventry, first, that GMC ethical standards regard 16-yearolds as competent adults, and also that treatment under anaesthesia for which the patient has not consented may be done only when it is intended to save life or avoid significant deterioration in health. Although views from a third party may be taken if the patient cannot decide, the GMC says doctors should consider the options that least restrict the patient's future choices.

In their response, the Coventry doctors admitted it was probably a "blessing in disguise" that the mother could not be found. They had also later discovered that the mother had concealed her dates (not unusual, we might think, when a pregnant 16-year-old is in casualty with her mother).

We find the muddled thinking of the Coventry doctors on the consent issue disturbing.

They had decided to go ahead with a caesarean largely because they had an anaesthetised teenager on the table; there were no signs that mother or baby was in trouble, so there were no urgent clinical grounds. She escaped a section solely because her mother could not be found at the crucial moment (that is, assuming the mother would have consented - and many mothers would have done so if told by doctors that it was necessary).

Yet, the mother's 'consent' on her daughter's behalf would have been legally and ethically worthless. The young woman, at the beginning of her reproductive life, would have an unnecessary scar on the uterus that would increase her childbearing risks, and affect any future children. I wonder what it would have done to her relationship with her mother if she felt her chance of giving birth had been stolen from her - as so many of our clients do? And what about bonding with the baby-born under a general anaesthetic to a mother who, so far as the doctors knew, did not even realise at the time that she had a nearly full-term pregnancy?

References

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2. Morris C. A response to 'Anaesthetised for evacuation of retained products'. Anaesthesia, 2003; 58: 1147-8
3. Ranganathan M, Raghuraman G. Ethical considerations in obtaining consent under anaesthesia. Anaesthesia, 2003; 58: 1235-52