

Medical Humanities in Obstetrics: The Uncertainty to be Born

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Abstract

Medical Humanities are a multi-disciplinary field of research that promote increased awareness on the humanistic and cultural dimensions of health care. This discipline research about the profound effects of disease on patients and health professionals offering models and methods for addressing ethical dilemmas. They touch multiple disciplines such as literature, history, philosophy, anthropology, religion and arts. We will describe a case of an extreme preterm premature rupture of membranes, as an example of one of the most sensitive and debated issues in obstetric. The choice is whether to continue the pregnancy or to terminate it, being aware that there are no guarantees regarding the survival and prognosis of the unborn. We will see how medical humanities are crucial to improve the quality of care with the help of narrative medicine.

Keywords: Medical humanities; Extreme preterm premature rupture of membranes; Narrative medicine; Ethic issues

Introduction

Every physician throughout his career has to deal with unexpected ethical dilemmas. Even more obstetrician-gynecologists have to face complex ethical questions regarding all of the major stages in life, birth, reproduction, aging and death. Neither medical nor nursing education prepares adequately future clinicians for these realities of practice. For this reason medical humanities have become mandatory in the medical training. Although it is hard to define properly medical humanities, it can be stated that they are conceived to overcome the separation between clinical care and human sciences and to optimize the patient care by educating and training the physicians at analyzing and resolving dilemmas in clinical ethics [1,2]. The purpose of this article is to describe the relevance of humanities to the interdisciplinary education and practice of health care providers on a particularly sensitive issue. We discussed a case of conservatively managed case of extreme preterm premature rupture of membranes (pPROM).

Case Report

A 27-year old primiparous patient was admitted to the Gynecology and Obstetrics University Hospital in Novara, due

to suspected premature rupture of the membranes. There was no associated fever, abdominal pain, urinary symptoms, trauma and any history of vaginitis. Her vital signs and blood test were regular. Obstetric examination confirmed clinically rupture of the membranes and ultrasound scan showed single viable fetus with oligohydramnios and no anomalies. Biometry corresponded to 19 weeks and the estimated fetal weight was 340 g. The cervix was closed with normal depth and the uterus was soft, not tender. The patient was given the option to terminate the pregnancy at 19 weeks but she and her husband decided against that, so she was kept in the hospital for conservative management after proper counseling. Prophylactic antibiotic with Amoxicillin was started. The temperature and the bi-weekly complete blood counts and microbiological screening for infections remained normal. Serial ultrasound scans showed the presence of progressive fetal growth despite of persistent oligohydramnios. Suddenly, at 25 weeks, the patient was urged for immediate delivery because of warning signs of intra-amniotic infection. These signs included fever, abdominal pain, vaginal spotting, foul-smelling discharge and rapid heart rate. The patient delivered a live preterm female baby by breech presentation. The baby weighed 750 g and apgar scores were 4 and 6 at 1 and 5 min, respectively. Due to persistent hypotonia and hypo reactivity, signs of respiratory distress, she was intubated and transferred to the Neonatology Intensive Care Unit (NICU). During the period of her stay in NICU, the baby was diagnosed with intraventricular hemorrhage and neonatal sepsis and she was discharged at day 54 of life. The child showed abnormal neurological behavior (agitation, uncontrolled movements, and delayed motor development) at six months of follow up.

Discussion

This case shows the hardships that families and healthcare professionals face when dealing with such situations. pPROM prior to fetal viability is a unique and relatively rare problem that is often difficult to manage. It occurs in less than 0.4% of all pregnancies [3]. Prematurity is the principal risk to the fetus, while infection morbidity and its complications are the primary maternal risks. The available literature suggests that pregnancy

with PROM occurring before 20 weeks of gestation, like in our case, is often associated with an unsuccessful outcome. Despite the advances in clinical medical practice, prophylactic and medical treatment of premature amniotic fluid loss, pregnancies like that will not often result in the birth of a healthy newborn [4]. The implementation of Medicine Humanities in cases like ours seems to be particularly indicated. An early pPROM is a challenge not only for the future parents, but also for the entire team of healthcare professionals. The decision whether to end the pregnancy or to continue it represents the greatest dilemma for obstetricians. High mortality and morbidity rates of extremely preterm infants, on the one hand, and prognostic uncertainty in individual cases, on the other hand, makes it difficult to decide in terms of ethics. Medical Humanities enable the understanding of disease through "human sciences" which encompass disciplines such as pedagogy, anthropology, philosophy, sociology, history, literature, poetry and the visual arts [5]. The physician caring for the pregnant woman plays an important role in management and needs to be familiar with potential complications and possible interventions to minimize risks and maximize the probability of desired outcome. From here, it can be seen as the preparation of the doctor which cannot be based only on scientific knowledge but must be supplemented by humanities. Obstetricians and neonatologists should inform both parents about the situation of the unborn child and his/her likely short- and long-term prognosis. Before that, the physician has to take some time to prepare himself to these stressful situation. This information should be precise and comprehensive and should be presented using appropriate expressions and understandable language. Parents should be given sufficient time to ask questions and to address unclear issues of the conversation. A wide range of reactions by parents has been reported. These includes everything from disbelief, fear and impotence to despair. It is very important that parents learn as much as possible about this critical situation; also health care team should support them by asking about their feelings. A good doctor must be able to enter not only the body but also the mind of his patient and to share with him the psychological weight of the disease. According to the Greek philosopher Plato, the greatest mistake physicians make is trying to cure the body without attempting to cure the mind, yet the mind and the body are one thing, hence they should not be treated separately. No one perceives the world in the same way, we all have a personal perception of reality and when a person gets sick, that same perception of the world changes. This is evident in the art in which the artist often makes the disease an integral part of his work. Just to think to impressionist Renoir who suffered from severe rheumatoid arthritis, or the painter Munch with a mental illness: would their works of art be the same hadn't the artists been sick?

In our case, after a long interview and a period to reflect, parents decided to continue the pregnancy. How can the chance of survival be balanced against the risk of dying or surviving with a severely restricted quality of life? Did the parents really understand the severity of the situation? Are they fully aware of the choice made? Since there is no possibility to prove the moral correctness of the decisions taken when facing an ethical

dilemma, successful decision making will be defined by how the parties involved cope with the consequences of the decision. The conservative treatment of pPROM before the week 20th of gestation is controversial; it is difficult to predict the eventual outcome for many factors impact on this – first of all the eventual gestational age at the moment of delivery. Expectant management should be adopted only in select patients who are well informed and educated about the risks and the dismal prognosis for the neonate. There are high rates of complications of extreme prematurity among surviving infants. This together with significant emotional, economic, social and psychological costs to the families emphasizes the need for explanations with all the means at our disposal clinical condition in order to find solutions that are in the infant and mother's best interest.

It would be useful to provide stories of families living a pPROM in order to convey an intimate knowledge of suffering and to connect the patient with others who are experiencing the same situation. Through construction and reconstruction of personal and social stories, parents and families have the ability to break free from anxieties and fears in a way that lies outside the domain of the biomedical voice. Narrating is a fundamental way of giving meaning to the human experience. Consequently, the interest of care team concerned with narration is focused on how people talk about events and not only on what is said [6]. As Anne Hudson Jones writes, after devoting her professional life to the development of the medical humanities: "to understand and accept a patient's moral choices, a practitioner must acknowledge that the illness narrative has many potential interpretations but that the patient is the ultimate author of his or her own text" [7]. Narration allows the sufferers to create a distance between them and their experiences and this relational space enables the reworking and overcoming. Narratives provide a framework for approaching a patient's problems holistically [8]. The narrative-based medicine fortifies clinical practice helps physicians and nurses to improve the effectiveness of care through the development of the capacity of attention, reflection, representation and affiliation with patients and colleagues. It is not a new science but an instrument of the therapeutic process in which one tries to understand and interpret not only the patient's disease history but also his experience.

Conclusions

Medical practice is dominated by evidence-based medicine but decisions about whom or when to treat or how to prevent the disease, cannot be made based on science alone [9]. It is necessary to consider medicine as a profoundly human enterprise and to learn a set of skills and knowledge to land on a suitable decision-making process when moral conflicts arise. It is now and here that medical humanities make their way; they are a growing field destined to become an integral part of the care program. Medical humanities are effective in improving the preparation of health careers for clinical professional life. Emphasizing science, without acknowledging the importance of the humanities, undermines the essential attribute of being a good physician [10]. According to Professor Umberto Veronesi, a revolutionist of contemporary medicine: "we must go beyond the traditional concept of body care and give space to the whole person, body and mind".

References

1. Gordon J. Medical humanities: to cure sometimes, to relieve often, to comfort always. *Med J Aust.* 2005; 182(1):5-8.
2. Surico N, Codecà C, Caccia S. Medical humanities in gynecology and obstetrics. *Minerva Ginecol.* 2012; 64(5):447-53.
3. Waters TP, Mercer BM. The management of preterm premature rupture of the membranes near the limit of fetal viability. *Am J Obstet Gynecol.* 2009;201(3):230-40.
4. ACOG Practice Bulletin No. 80: premature rupture of membranes. Clinical management guidelines for obstetrician-gynecologists. *Obstet. Gynecol.* 2007;109(4):1007-19.
5. G Donzelli. Medical humanities and narrative medicine in perinatal care. *J Matern Fetal Neonatal Med.* 2015;28(1): 1-2.
6. LC Hyden. Illness and narrative. *Sociology of Health & Illness.* 1997;19(1):48-69.
7. AH Jones. Narrative based medicine: narrative in medical ethics. *BMJ.* 1999;318(7178):253-256.
8. T Greenhalgh, B Hurwitz. Narrative based medicine: why study narrative? *BMJ.* 1999;318(7175): 48-50.
9. D Dysart-Gale. Lost in translation: bibliotherapy and evidence-based medicine. *J Med Humanit.* 2008; 29(1):33-43.
10. SC Weiss. Humanities in medical education: revisiting the doctor-patient relationship. *Med Law.* 2000; 19(3):559-67.