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Short Communication

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Navigating boundary crossings in obstetric practice

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Short Communication

Obstetricians and maternal-fetal medicine specialists as all clinicians frequently encounter clinical dilemmas in which professional boundaries conflict with the needs of a patient. In this article, I present a spectrum of problematic boundary crossings, propose approaches to make an obstetrician's challenge less emotionally painful, and finally apply these practices to parents undergoing the profoundly painful experience of neonatal loss.

Different boundary crossings involving ever-increasing losses and risks

Let us begin with a minor boundary crossing. Consider a patient who discovers on a Friday night that he has run out of sleep medication that he needs to be able to fall asleep. Panicked by anticipating his being awake all night, he contacts his physician. Should this physician take whatever measures are necessary to provide the patient with this medication? Should he do this regardless of what this may require? The personal cost to the provider—such as missing a pre-planned dinner engagement—may, for example, be substantial. Yet the effort this clinician takes to resolve such a problem may be more therapeutically significant than the clinical outcome itself.[1]

The difficulty for the patient may increase when a patient becomes angry. A common response more favored in the past involves providers "setting limits" by informing such patients that their behavior is unacceptable. This response may, however, permanently destroy the therapeutic alliance. A more difficult, yet often more successful approach is to view patients' shows of anger, initially at least, as a cry for help. By ignoring one's own sense of being wronged and seeking rather to understand the root of the patient's distress, this again may transform the encounter into one built on trust and, because of this trust, bring about deep healing.[2]

Legally fearful crossings may include acts of pure empathy at physicians' personal risk, such as when they volunteer to take an impoverished patient who can't drive to visit a partner in a long-term care facility an hour away, when, otherwise, the patient would not be able to see his partner. Colleagues may cite as a warning against this the lack of insurance coverage in this situation and accordingly the litigation risk that this may pose. The physician and patient may be in a serious accident injuring this patient. Since this would occur outside of the clinical setting, it would not be covered. These acts may, however, again, be incredibly beneficial and supportive for this patient, though they represent a humanistic response departure from professional norms.

A still higher stake dilemma may involve patients who face an irresolvable double bind. An example is patient who desperately wants to maintain a security clearance, but who has suicidal ideation. Here, the clinician optimally may struggle with the patient to try to find some way to minimize the risk of the patient's harming himself while at the same time enabling him to maintain his clearance. This may be possible through their agreeing to an exceptional arrangement, such as the patient and physician initially being in connect by phone every few hours and then to expand this time interval later if and as both see as a risk worth taking.

Two approaches to resolving these dilemmas

I am presenting these increasing boundary dilemmas to establish background for obstetricians considering a most challenging dilemma.[3] This is how they should respond when parents give birth to a stillborn fetus or child or it is certain the child will shortly die. The parents may be in shock and have no interest whatsoever in seeing this child. Yet, these parents may gain immensely if they do. Should then their providers inform them of this likelihood even though these parents may find this immensely insensitive and also be traumatized as opposed to benefiting from this?[4]

Considering these other arguably lesser challenges posed may be helpful to some providers. First, they may imagine all these conflicts as lying along a spectrum from least to most conflictual. They may then see where along this spectrum they would want to draw a line. They in doing this re-contextualize this choice as one among others. They acknowledge that they are choosing between many similarly challenging options, not just this one. This may help take away the connotative sting that from their deciding just this one case.

A second course, having done this, is to assess whether their decision regarding the case at hand is or is not consistent with how they would respond to case on this theoretical spectrum lying just before theirs. They can do this by first discerning the critical moral elements in their case and then them conceptualizing them as in the form: *When conditions A and B exist, do X.* They may then seek to discern whether the case before theirs has just these same moral elements, only A and B. If so, and they would come out the same way in both cases, they would be consistent. If not, they must reconsider. Either their first analysis and resolution are wrong or there is a third morally relevant factor, *C*, in their case. Even if they are consistent, this doesn't mean that their resolution is the right of best one. Their applying this analysis for consistency may, however, leave them feeling more confident that they have done the best that they can.

What should obstetricians say to parents after they have given birth to a stillborn baby or a child who will shortly die?

In the immediate shock of a stillborn fetus or an infant or who will surely soon die, parents may recoil and request that their baby be removed immediately to avoid further emotional trauma.[5] However, clinical experience and evidence present a contrary, paradoxical

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possibility. This is that parents in these situations may come to value greatly brief time spent seeing and holding their child. They likely, of course, must know this to be able to overcome their shock and grief sufficiently to be willing to do and find how they respond, though holding may be more painful for them than their just looking at their child.[4] The obstetrician's informing these parents of the possible benefits and downsides of their doing this so that they then may be more likely to choose this option is then critical. This may transform their life-long memory from one of pure trauma to one of positive recall.[6]

The difficulty for obstetricians stems from their having to do this at the height of these parents' grief.[7] Current best practices emphasize that clinicians inform parents of the pros and cons of their doing this and pre-informing them what their baby looks like if this would at all reduce their shock when they first see their baby. I would add that it might here even be preferable for clinicians to ask them if they would want this preliminary description. Parents have felt deep regret that they have not done this.[8] There may also be cultural practices involving holding and washing that doctors might especially know of so that they can accordingly alter what they will do if this seems indicated.[9]

Conclusion

If parents decide to see and hold their child, this may reduce their risk of having post traumatic pain and in its place create long-term psychological healing.[10] Though there is now agreement on what obstetricians should do in this instance, namely inform parents of this option in a non-coercive manner, their doing this may be difficult for providers. Some parents may see their doing this as supremely insensitive. Providers may reduce the foreseeable pain of doing this by considering this choice in a broader context of other similar conflictual choices as outlined above. They may see this as just one along a spectrum of ever increasingly hard choices. This may help them to des this decision as one among many that inevitably tend to arise. They may also assess whether their choice is consistent with other choices they would make. If yes, they might feel better about both or if not, they would at least be clearer about the new unprecedented choice they are making.

Providers all too often struggle with decisions such as this alone. Here in addition to consulting with others, which is the best antidote for excruciating emotional angst, two cognitive tools are provided that may be of some help when they are all on their own.

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Conflict of interest

There is no Conflict of interest.

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