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THE PLACE FOR NEONATOLOGIST IN PROPER PERINATAL CARE
- COMMENTARY

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The neonatal specialty is different from that of pediatrics as it requires (among other differences) the knowledge of fetal development in terms of physiology and pathology. The neonatologist knows the importance and impact that suboptimal conditions during intrauterine growth have on the baby's condition at birth. They must anticipate the child's needs and know what complications can be expected. This is a fundamental issue, because without being able to predict complications, one is unable to counter them, and if they occur, they usually leave a mark in the child's future condition. The neonatologist should not, and can not say he is uninterested in the future of his young patient, that it is a matter for pediatricians, parents, etc. Let's see how things look in practice.

The discharge papers including the many months of stay in the neonatal intensive care unit start with information regarding delivery and state of child upon birth, as if it were the beginning of the child's development. " . "Insufficient information about the results of prenatal tests, combined with delayed inclusion into multi-specialist teams and the process of consultation, constitute the main causes of interpretative difficulties for neonatologists." I absolutely agree with the second part of the quoted sentence from the commented article, but the first part I intend to argue.

While preparing to begin treatment of a child that is about to be born, the neonatologist reaches for obstetric records in which he encounters many ultrasound examinations, performed predominantly at the end of pregnancy, they contain a variety of very detailed descriptions and usually without any summary or drawn conclusions. It's hard to resist the impression that there was no coordination or overall vision of what is to follow. So what is missing in the logistics of prenatal diagnosis? Where can we find an optimal model to follow? No need to knock down doors, they have already been opened several years ago. Anyone who has visited the perinatal centers in Western Europe or in the U.S., is well aware that in such centers interdisciplinary teams always work together, they discuss the optimal treatment plan in the case of fetal

malformations. It is well aware that complex and difficult to manage cases exist. Why should the obstetrician performing the ultrasound be obligated to make decisions regarding such difficult cases?

The interdisciplinary team (in the Mother and Child Institute in Warsaw, where I work, is called the interdisciplinary team for the Diagnosis and Therapy of the Fetus and Neonate), in addition to the obstetrician and neonatologist it also comprises of a geneticist, pediatric surgeon, cardiologist, a specialist in the field of diagnostic imaging, and If necessary, also other specialists. In this group medical information regarding the patient - the fetus and the mother, is discussed. This model of care allows the detailed discussion of all the available opportunities, it enriches individual experience, and - as this is very important - teaches young doctors. There should not be room for any bilateral consultations, especially via telephone, without the possibility of reviewing medical documentation and imaging results as this course does not prepare the team for the tasks awaiting after the birth of the child.

In some cases, the period after 22 weeks of gestation is already too late for some options. If a lethal defect is suspected, it is too late, to ascertain the fetal karyotype before the end of 23 weeks of gestation. In Poland, it is assumed that a 23 - week-old fetus after birth can survive "independently " and thus the condition of viability is met, which closes one path stated by law.

Under Polish law, parents aware of the serious nature of the defect/ multiple malformations of their child can apply for termination of pregnancy. In these cases what is the role of the multidisciplinary team? The team decides whether a case meets the criteria required by law. This does not mean that the team makes the decision, because obviously it's up to the child's parents, and is dictated in brief, by their professed hierarchy of values. It is not the role of a doctor to evaluate the decisions which are not their own to make.

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In contrast, in cases where the diagnosis of a lethal malformation is certain- proceeding with resuscitation (because it is the wish of the parents) is futile and not in the best interest of the child.

The decision to initiate resuscitation and / or continue medical treatment is the decision of the physician (medical consyilium, treating team or the ethics committee) and not the parents. This does not mean, however, that the parents and their will should be ignored. This decision relates to them directly, and therefore requires the discussion with the lead physician. You have to enable parents who are shocked, in despair, and usually without medical knowledge, to "free their thoughts", which is always the basis for any discussion, debate and presentation of arguments. It is good if a psychologist experienced in the field of perinatology, is involved in this process. It seems that the most important thing to which we should aspire in contact with parents, is to build their confidence and trust in what we do and say. If we are successful, we will also gain the parents understanding.

Outlined above is a model for proceeding in medically and ethically complex situations and is based on specific processes rather than a single consultation among specialists.

Now imagine a situation in which a patient whose child is diagnosed with a severe malformation, under the care of a perinatal reference center, decides to continue with the pregnancy, but to give birth in a hospital with a lower reference level, but closer to home. Can you be sure that the decision made together with the treating team regarding postnatal palliative care will be understood and respected in the small hospital? I am afraid that there is no such certainty. Can you be sure that after the death of the child a detailed autopsy will be performed, which is absolutely necessary to confirm the accuracy of the medical decisions?

Certainty is difficult to ensure in such cases. It follows that referring patients from the treating centre, aware of all aspects of the malformataon is risky, at least until widely used recommendations are developed. Neonatologists have succeeded in developing Recommendations for dealing with the mother and neonate born on the verge of survival, taking into account ethical aspects. There is still a lot of work to be done, guidelines regarding palliative care of the newborn and management in cases of complex malformations are yet to be developed.

I would like to add to the list of examples of congenital malformations requiring delivery in referral centers presented in the commented article, one which requires immediate surgical treatment. That is the evisceration of abdominal organs, in which case any form of transport is a very bad option, as it prolongs the time of closure of

the abdominal wall, which causes edema of the intestines increasing their volume which makes it more difficult to insert them into the abdominal cavity. Moreover, during transport the mesentery is pulled which is the cause of significant pain. The best solution is to deliver the child in close range to an operating theatre, where a team of surgeons and anesthesiologists await. An important role of the neonatologist is to provide adequate information to the lead pediatrician or family doctor that will take over primary care of the child. Currently the process of adapting the child's medical record book to meet the needs existing today is underway. I hope that this document will once again become the binding medical document and meet all the requirements we hope it will fulfill.