

ETHICAL AND MEDICAL ASPECTS RELATED TO EXTREME PREMATUREITY

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The contemporary interest in bioethics is the result of progress in medicine. We are now increasingly facing philosophical, ethical moral and financially-related problems. From fetal rights to caring for extremely premature infants, the severely damaged or chromosomally abnormal newborn, to the questions raised by artificial insemination, human experimentation and mother surrogates.

We are constantly confronted in our daily practice with moral problems. The way in which we tackle these difficulties may depend on our understanding of medical ethics.

The term “medical ethics” is used in a variety of ways. In its narrowest sense, it refers to a body of codes of conduct developed by the medical profession. The Hippocratic Oath is an example of the ancient origins of this endeavour.

Medical ethics, in a wider sense, is bioethics – that is a systematic reflection on what is right and wrong in the practice of medicine.

A single conflict has characterized the field of medical ethics throughout history: the tension between lay persons and physicians relating to decision making.

It is also important to realize that the field of bioethics is not only under the influence of medicine – its traditions and its developments – but it is also affected by other changing forces such as public reputation, political ideologies and economic conditions.

At the threshold of viability, critical decisions have to be made often without much time for extensive consultation between physicians and parents. The decision whom to resuscitate and to whom to provide prolonged neonatal intensive care remains one of the most difficult decisions in the practice of neonatology. With a dramatic improvement in the survival of infants born between 23 and 26 weeks of gestation, survival is not any more a “medical miracle” but a reality that needs to be evaluated with all its long term potential implications for parents and society at large. It is unfortunately clear that at the lowest limits of viability, survival is often associated, for a large number of infants, with significant short and long term complications. Hence, it is of paramount importance that extensive consultation between parents and physicians take place prior to delivery. This is possible in the majority of situations.

Data presented to the parents on survival and potential complications should reflect local epidemiological information and not general statistics because the expertise and outcomes differ considerably from one country to another and from one institution to another, as do medical, social, cultural and economic factors.

The legal implications of poor communication between parents and physicians cannot be understated. According to local data, parental decision for full medical intervention can vary widely between 23 and 26 weeks of gestation. It is also evident that differences in physicians' personal beliefs can seriously impact on parental decision.

However, the prevailing view is that treatment decisions at the very limit of viability, when the outcome is uncertain or ambiguous, should be the prerogative of those who bear the responsibility for the infant – the parents. On the other hand, the physician's responsibility is to protect the life of an infant from unreasonable demands from the parents and to work in the best interest of that infant.

At the very end, effective communication between obstetrics, neonatology and parents can prevent conflicts and suffering.