Dilemma for patient and clinicians

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Abstract
The story of Maria Tomasa is deeply moving. Tommy went through a difficult process to find support in her wish to have a child. Then she risked her health in this pregnancy. Finally, she accepted that her story be told and commented on by strangers. All three steps show admirable courage. The authors must also be commended for publishing a case highlighting several issues on which reasonable people may disagree. Without attempting definitive answers, we comment on a few points illustrated by this story.

Reference

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Many of the rapid responses point out that there is a paucity of evidence of the risks of ovarian stimulation and pregnancy for people like Tommy. Even if all the risks were quantifiable, they may be ignored by couples whose lives become dominated by their desperation for a child. In reproductive medicine we see couples who risk their relationships, jobs, homes, and health for an attempt at in vitro fertilisation. At what level of risk do we say no?

Competing interests: None declared.

Commentary: how can experts and novices learn together?

Ed Pelle

Rapid responses to this case have been less numerous than expected, contributing? We know that experts and novices learn differently. Novices may learn from seeing how experts develop their reasoning, and experts exposed to the thought processes of the less experienced may reflect on their unconscious expertise.

Much of modern educational thinking about professional learning is founded on Lave and Wenger's notion that learning is "a process of participation in communities of practice, participation that is at first legitimately peripheral but that increases gradually in engagement and complexity." BMJ interactive case reports attempt to stimulate the formation of a transient community of practice on the web pages. Gilly Salmon coined the term "cafélattia learning" to describe online communities, such as those with a common professional interest, learning by being intellectually extended by dialogue and challenge from others. She has valuable advice for those facilitating e-learning in this context.

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Commentary: dilemma for patient and clinicians

Samia A Hurst, Alex Mauron

The story of Maria Tomasa is deeply moving. Tommy went through a difficult process to find support in her wish to have a child. Then she risked her health in this pregnancy. Finally, she accepted that her story be told. It obeys the laws of nature and was clearly "unnatural". It was a process of participation in communities of practice, participation that is at first legitimately peripheral but that increases gradually in engagement and complexity.

Refers to: BMJ interactive case reports attempt to stimulate the formation of a transient community of practice on the web pages. Gilly Salmon coined the term "cafélattia learning" to describe online communities, such as those with a common professional interest, learning by being intellectually extended by dialogue and challenge from others. She has valuable advice for those facilitating e-learning in this context.

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5 Turone F. Italy to pass new law on assisted reproduction. BMJ 2004;328:9.
Firstly, the imperative to "do no harm" is not straightforward in this case. As Trisha Greenhalgh points out, there are risks involved whatever choice is made, and the weight that should be given to these risks is a personal assessment. So the imperative not to harm is not clearly in contradiction with patient self determination. Tommy knows best what would be most harmful to her: the possible adverse outcomes of pregnancy or not having this child.

Commentary: beyond the evidence
Gillian Hawthorne, Maggie Blott

Tommy's story shows the difficulty that is often encountered when looking after women with complex medical problems in pregnancy. There is simply insufficient evidence to customise the personal risk for a woman with diabetic complications who wishes to become pregnant. Women like Tommy need consensual advice and support from a highly skilled, well informed, multidisciplinary team with a good understanding of the complexity of the issues and the necessary skills to provide the required care. Good preconception care should, and in this case did, underpin the management and must include counselling about risk. This is not a generalist case, and we are not surprised that there were few rapid responses to this case.

Tommy changed her diabetes team in search of support for her desire for a baby. Once she made her decision, the ongoing support of the care team was paramount, whether or not they fully agreed with her. The failure to refer Tommy earlier for assisted conception when it was clear that there was a mechanical barrier to conception may have been a symptom of the team's ambivalence but not of their lack of commitment.

Assessment of diabetic control, diabetic retinopathy, hypertension, cardiac status, and renal function are vital before pregnancy. Glycaemic control can be optimised, blood pressure stabilised, and folic acid started. Ischaemic heart disease is an absolute contraindication to pregnancy, as suggested by the rapid responses. Angiotensin converting enzyme inhibitors can be continued until the pregnancy is diagnosed; they are not known to be teratogenic.

Reports suggest that outcome of pregnancy is generally good in women with mild to moderate diabetic renal insufficiency, with a 90% take home baby rate. The woman would be at risk from pre-eclampsia, with attendant risks of intrauterine growth restriction and intrageneric prematurity for the fetus. Aggressive control of blood pressure is therefore essential. No consensus exists on the effect of pregnancy on progression of diabetic nephropathy to end stage renal failure, although women with more severe disease are less likely to recover renal function after delivery of the baby.

The risks of in vitro fertilisation in women with diabetic nephropathy have not been evaluated. As women with diabetic nephropathy have a shortened life expectancy, however, issues surrounding the welfare of the child must be discussed before treatment. Pregnancy is not without risk. Care must be tailored to the individual and delivered by a team with sufficient expertise to provide the skilled support that women need.

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Clinical review

This also reminds us that evidence based medicine is a source of factual knowledge. No less, but no more. It will not, by itself, solve ethical difficulties. Knowing what should be done certainly includes knowing the facts—the team was correct to go to the literature with such care—but the difficulties do not end there.

This difficulty with medical decision making is not, of course, Tommy's problem. Her decision, whether to endanger her body in order to give birth, is one that women were already facing long before people started writing about it. Only recently did inventions of the human mind make this risk more distant and less generally accepted.