COMMENTARIES

A Corner of Control

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Keywords: labor and delivery, medical student, patient care

https://doi.org/10.52504/001c.87495

Georgetown Medical Review

Vol. 7, Issue 1, 2023

"A Corner of Control" is a story about "Sarah" (pseudonym), a young woman identifying as Black American who was urgently referred from a routine prenatal visit to the labor and delivery antepartum triage unit for decreased fetal movement and was told by the inpatient obstetrics resident/attending team that she needed to be admitted for induction of labor. Feeling backed into a corner, she decided she wanted to leave against medical advice. I, the medical student, was responsible for mediating between the 2 parties, navigating my position at the bottom of the team's hierarchy with my duty to listen and provide the best care to my patient. The story ventures into our fear and compulsion in carving a corner of control by implementing treatment courses that could significantly impact not only my medical career and the hospital's reputation, but most importantly, Sarah and her baby's life.

At 9 months pregnant, Sarah sat in the triage unit on the Labor and Delivery (L&D) wing, waiting for the on-call OB/GYN to see her. As a third-year medical student and on the first week of my L&D rotation, I walked into Sarah's holding bay in my short white coat and greeted her.

"I don't know why I'm here," she said curtly. "I'm fine, and my baby is fine."

I read the notes from her outpatient OB/GYN clinic visit, which stated "decreased fetal movement for 2 days, late to establish care, several missed appointments, planning for home birth."

I stepped out to discuss the case with the team, including a senior resident and the on-call attending physician. After we reported the history and examination findings, the senior resident said, "She has oligohydramnios. Let's admit her and start induction of labor." A deficiency in vital amniotic fluid could cause serious lifelong injury. The baby could die.

I was taken aback. "But she wants a home delivery," I said.

My concerns were noted but ignored. We went back into Sarah's room, hospital admission paperwork in hand. The senior resident led the discussion, explaining the ultrasound findings and the risks to the baby's health. When the attending recommended admission, Sarah became upset.

"I knew this would happen if I came here," she exclaimed. "I'm going home."

Our team tried to counsel Sarah. Once again, we cited the ultrasound findings and potential risks. Sarah remained adamant: She would not deliver in the hospital and demanded to be sent home.

We left Sarah's room. Several other mothers on the floor needed the team's attention; there were pressing emergencies we had to address. We didn't have the time or energy to argue with someone so determined to act against medical advice (AMA), especially since, despite the risk, the baby was still stable.

When I donned my white coat for the first time, I took an oath to "do no harm" to my patients. That same oath also asked me to defer to my seniors and teachers, even when I disagreed with them. I felt trapped. I couldn't shake the feeling that I was not acting in this patient's best interest. My intuition told me Sarah was surprised at how quickly her pregnancy and the plans for her delivery were unfolding. *There must be some part of her that understands the risks*, I thought, wondering if I still had a chance to intervene.

As a medical student without the same clinical load as my attendings, I had some leeway they didn't have. Maybe there was an opportunity here to fulfill my role as a patient advocate. If only I could just take a moment to listen to Sarah and her concerns, then maybe, I thought, something might change. I implored the team to let me talk to her again, even as I saw that they were in the middle of drafting the AMA discharge paperwork. To my surprise, they agreed to let me try.

My newfound latitude empowered me. I returned to Sarah and did what most medical students do best: listen.

I learned that Sarah wanted to be the driver of her delivery and felt she could maintain this oversight with an at-home birth at 40 weeks in a calming, familiar environment. She wanted her partner by her side, a flight attendant who was currently 50,000 feet in the air. Most of all, she wanted to feel valued and know that her experience mattered to the medical team.

"You doctors don't care if my baby and I die as long as you can bill for it," she said.

Her fear was certainly understandable. A recent Centers for Disease Control and Prevention study[1] indicated that Black mothers experience a pregnancy-related mortality ratio of 40.8 deaths per 100,000 births, the highest among all racial and ethnic populations. This reflects a health care institution that has placed Black and other racial and ethnic minority patients in a system of bias[2,3] and disparate provision of care in the perinatal period. Data from a study published in the *Journal of General Internal Medicine*[4] found that Black patients have approximately 23 minutes less face-time per office visit with their clinicians than their White counterparts, leading to more missed diagnoses and less consistent care. In the context of larger atrocities like the Tuskegee experiment,[5] coupled with smaller but equally painful aggressions[6] against Black patients, Sarah's apprehension towards formal medical care was undeniably justified.

After letting Sarah say her piece, I asked her to consider her health situation and the very real risks.

"What would make you comfortable starting labor in the hospital?" I asked.

"I just need one hour to get my bag from home and call my family," she said, surprisingly.

I went back to the team and shared Sarah's reasons for wanting to leave, particularly her pointed distrust of hospital protocols and the health care system in general. I asked the team to consider the lasting, positive effects we could have in following her lead and trusting her to come back.

Even in advocating for Sarah, I knew I was taking a chance. If she did not return as promised, I could be responsible for any serious injury she or her baby experienced. There was also a risk of liability to the physician team and the hospital.

To my shock, my attending agreed with Sarah's plan. There would be no AMA paperwork; no ethics committee would be needed to discuss the situation. Our standoff had evolved into a shared decision between the providers and the patient that respected both the clinicians' medical concerns and the patient's autonomy.

Deferring to Sarah's wishes set the tone for the remainder of the pregnancy. She eventually returned, as promised, and began an induction of labor. When she didn't make progress for over a day and a decision was made to recommend a cesarean delivery, we anticipated she would show some resistance as before.

"I knew you guys would do this if I came here. I told you I wanted a *natural* birth."

We explained to Sarah our rationale—but this time, with particular sensitivity to her feelings (we had learned our lesson). She asked for some time to think, which we gave her, albeit mindful of the ticking clock. We knew better than to deny her the little bit of flexibility she needed. Indeed, she initially did not want the operation and assumed her worst fears had been realized. But she allowed herself to be convinced that this was the best course for the baby. She trusted us–we had her best interest at heart during her admission, and we continued to have her best interest in mind throughout her labor process.

She looked into my eyes, took a deep breath, and said, "I'll do it."

I was thrilled. We had convinced Sarah that not only were we concerned for her health and welfare, but also that we knew how to listen and give her control in her pregnancy journey. I accompanied her to the operating room and helped deliver her beautiful, completely healthy baby girl.

The next day I came to work, invigorated with the lessons learned from being Sarah's advocate. As I walked in, the nurse handed me a card. It was from Sarah, grateful that when she felt backed into a corner, we gave her the attention she deserved and made her feel cared for. I put on my short white coat and greeted the first patient of the day with open ears.

The viewpoints expressed in this article represent the author's own and do not reflect that of the affiliate university or institution.

Ethics approval and Consent to Participate

N/A

Consent for Publication

N/A, Patient's name has been pseudonymized such that patient has been completely deidentified.

Availability of Data and Materials

N/A

Competing Interests

None to report

Funding

None to report

Author's Contributions

JG was the primary contributor in writing the manuscript, and read and approved the final manuscript.

Acknowledgments

Dr. Anuj Garg, Mrs. Ekta Garg and Dr. Caroline Wellbery

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