Surrogate decision-making in crisis

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Abstract:

Care around the critically ill baby includes supporting the birth mother/parents with regular updates around the clinical condition of her/their baby, and inclusion in discussions around complex decision making issues such as the continuation or discontinuation of life-sustaining-support. Difficult in the most straightforward of cases, but what happens when the birth mother is critically unwell, and there is uncertainty around who should assume the parental role for these difficult discussions around their baby? We raise, in this round table discussion, the ethical, moral and legal uncertainties this issue poses to neonatal teams, in the context of surrogacy.

Case:

A male same-sex couple in the UK entered into a non-commercial arrangement with an unrelated surrogate mother. The surrogate mother (M) agreed to become pregnant using donor sperm and her own eggs. The plan was for the intended parents (IP) to take over the care of the baby after birth, and for this to be formalised with a Parental order through the court.

Unexpectedly, the surrogate mother became severely unwell midway through the pregnancy. At 23 weeks gestation, she developed headache, altered conscious state and collapsed at home. An ambulance was called, and she received emergency treatment, including a period of cardio-pulmonary resuscitation on the way to hospital. Her circulation was restored prior to arrival at the emergency department, and she was diagnosed with an acute subarachnoid haemorrhage. She was admitted to the neurosurgical intensive care unit.

Because of the severity of her illness, a decision was made to deliver the baby. A preterm female infant, Baby T, was delivered by emergency Caesarean section at 23 weeks and 5 days gestation. Baby T was born in a poor condition, was immediately resuscitated and offered full intensive care support.

Baby T was critically ill in the first two days of life, and there was concern that she had suffered, as a consequence of the mother's cardiac arrest, hypoxic ischaemic brain injury. She had seizures which required anticonvulsant medication to suppress, and had evidence on ultrasound of a large unilateral intraventricular haemorrhage.

Appropriate parent consultations were needed, firstly, for an update regarding the condition of baby, and in the second, to commence discussions around the possibility of withdrawal of intensive care given the baby's uncertain and concerning prognosis.

M remained unconscious in the neurosurgical intensive care unit. It was unsure when she might regain consciousness and there were significant concerns about her own neurological prognosis.

The intended parents were at Baby T's bedside constantly. They were distressed and anxious, and were seeking to be included in understanding the clinical course, and potential plans for the baby. They expressed some uncertainty about whether it was the right thing to do to continue life support for baby T.

However, the clinical team were unsure of their ethical and legal obligations. The intended parents were not yet legal parents. There was no legally binding surrogacy arrangement. Who should decide for baby T, and should life-sustaining treatment continue?

References:

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