

Balancing Patient Autonomy with Evidence-Based Practice:

Delivery and Complex Postpartum Care

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Introduction

Learning Objectives

- To present a complex obstetric case involving multiple maternal and fetal complications.
- To explore how patient autonomy, mistrust of providers, and limited health literacy complicated evidence-based care.
- To highlight challenges in delivering patient-centered care in the setting of multidisciplinary management and critical illness.

Introduction

Evidence-based obstetric care relies on shared decision-making, informed consent, and trust between patients and providers. Patients with prior trauma, psychiatric comorbidities, and limited health literacy may experience heightened mistrust and distress during complex hospitalizations. This case illustrates the ethical and practical challenges that arise when patient autonomy conflicts with recommended medical management in a high-risk obstetric setting.



Figure 1: X-ray demonstrating post-operative ileus.

Case Presentation

- The patient is a **33-year-old G3P1011 with a past medical history significant for polycystic ovarian syndrome, panic disorder, major depressive disorder, and post-traumatic stress disorder who presented with a dichorionic diamniotic twin pregnancy conceived via in-vitro fertilization.**
- Her obstetric history was notable for one prior cesarean delivery performed for non-reassuring fetal heart rate status (NRFHRS).
- The current pregnancy was further complicated by the presence of four large uterine fibroids, including two located in the lower uterine segment measuring greater than 5.5 × 5.5 cm.
- Despite extensive prenatal counseling regarding the risks of trial of labor after cesarean (TOLAC)—including risks of uterine rupture, failure of descent due to the large lower uterine segment fibroids, and the potential need for a classical cesarean section with implications for future pregnancies—the patient strongly desired a TOLAC.
- At 37+3 weeks gestation, the patient underwent induction of labor.
- Due to NRFHRS and failure to progress, she ultimately consented to a stat cesarean delivery. **Intraoperatively, fetal extraction was complicated by large uterine fibroids compressing the presenting twin's fetal neck, necessitating extension of the hysterotomy from a low transverse incision to a T-incision and ultimately a cruciate incision.**
- Her postoperative course was marked by multiple severe complications, including postpartum hemorrhage of approximately 1600 mL, preeclampsia with severe features, pulmonary edema, acute respiratory distress syndrome, and acute kidney injury with a peak creatinine of 3.6 mg/dL.
- On **postoperative day two, clinical deterioration prompted further evaluation, which was concerning for endometritis and colonic pseudo-obstruction.** She was subsequently transferred to the intensive care unit (ICU) at a sister hospital for management of hemodynamic instability and bacteremia.
- During her ICU course, **the patient declined several evidence-based interventions,** including reinsertion of a nasogastric tube, administration of neostigmine, electrolyte repletion, and blood transfusion. She also declined specialized nutritional support, ambulation, and alternatives to opioid analgesia.
- As her care transitioned across multiple specialty teams, she reported increasing frustration with perceived inconsistencies in treatment recommendations and felt that communication among teams was inadequate. Although multidisciplinary meetings involving obstetrics, general surgery, internal medicine, and social work were held to align care plans and improve communication, the patient's dissatisfaction persisted.
- She expressed discomfort with trainee involvement and ultimately requested that only specific attending physicians participate in her care.
- She was eventually transferred back to the original hospital where her care teams attempted to streamline communication and decision-making prior to patient counseling. Despite these efforts, mistrust continued. Ultimately, she was discharged on postoperative day 14 after meeting discharge milestones.

Conclusions

This case underscores the complexity of balancing patient autonomy with evidence-based care in high-risk obstetrics.

- Despite extensive counseling, multidisciplinary coordination, and patient-centered interventions, mistrust and unmet expectations persisted.
- The patient's dissatisfaction appeared rooted in a perceived lack of control over her care and recovery.

This case raises critical questions regarding:

- Limits of informed consent.
- Managing refusal of recommended treatments.
- Communication strategies in prolonged, multidisciplinary hospitalizations.

Ultimately, this case highlights the need for continued discussion on how to support trust, autonomy, and shared decision-making in patients with complex medical and psychosocial needs.

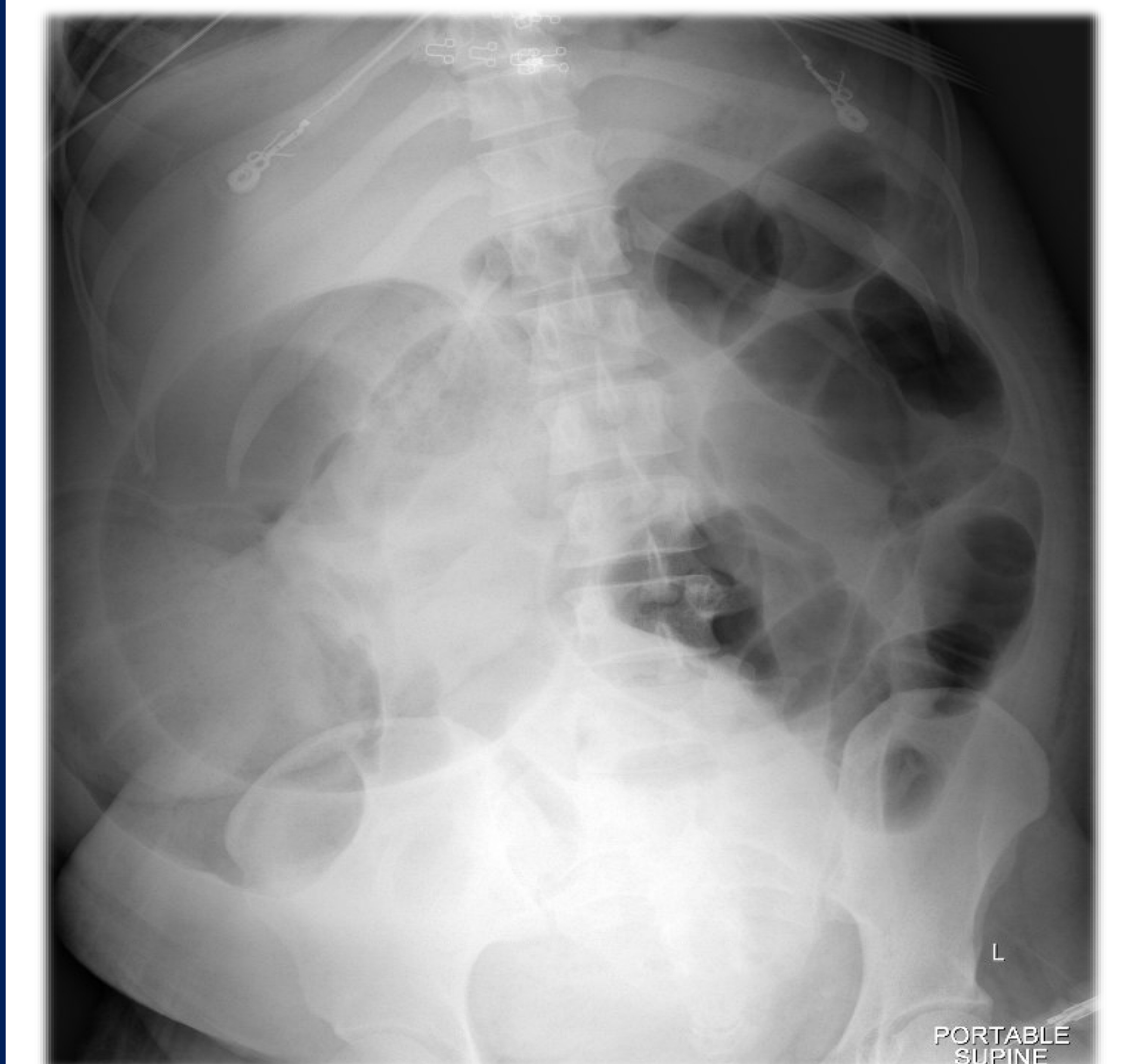


Figure 2: X-ray demonstrating suspected pseudo-colonic obstruction.