The Responsibility of the Reproductive Endocrinologist: The View of the Neonatologist

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By OBGYN.net Staff [1]

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Dr. Hugo Verhoeven: “My name is Hugo Verhoeven from the Center for Reproductive Medicine in Dusseldorf, Germany. I have the exceptional honor to talk this morning with Professor Manuel Carrapato from the University of the Porto. He is President of the European Association of Perinatal Medicine and the President of this meeting here in Porto, namely the European Congress of Perinatal Medicine. I’m actually reporting from this very important meeting. Professor Carrapato, I’m very glad that you, as the President of the European Association are willing to give me this interview. As you know, I am on the Editorial Board of OBGYN.net especially for infertility problems, and I am convinced that most of our listeners are especially interested in the pregnancy rates of reproductive specialists. By selecting the Reproductive Center of their choice, the outcome is the most important for the patients. But pregnancy alone is not everything. As specialists in Reproductive Medicine, we are creating very often problems. After the infertility treatment, these problems are anymore our problems, but the problem of the obstetrician who is going to take care of the patient and the neonatologist who is going to take care of the baby. You are going to be responsible for the lack of responsibility of doctors performing reproductive medicine. Tell me something about your thoughts on this topic and especially, what can go wrong with multiples after artificial reproductive techniques. Once again, thank you for giving me this honor.”

Professor Manuel Carrapato: “It is, in fact, my pleasure and privilege. Indeed, as everybody knows, we have different techniques in the field of reproductive Medicine available. A very important question is : are we counseling our patients about these techniques and especially about the risks? The decision of the patient what technique to choose should be performed after extensive counseling. Often counseling is performed after reproduction happened. The problems are created, so let us talk now about the problems we produced.”

Dr. Hugo Verhoeven: “So you mean that the doctors specialized in reproductive medicine are talking with their patient just about what they are doing but not about the consequences, of what’s going to happen as soon as the pregnancy is achieved, is that what you’re saying?”

Professor Manuel Carrapato: “Exactly, sometimes they do the counseling when it’s too late because reproduction has already taken place. That’s the first question. A second big problem is the use of ovulation inducting drugs. Many doctors are using these drugs without thinking about the consequences. They start the treatment and after a multiple pregnancy is produced, they ask themselves the question : what did I do? To go back to IVF, another big problem is : how many embryos should we give back. Is it really important to give that many embryos back? I think more than two or three should not be transferred. We come now to the next problem : the problem of fetal reduction. I’ve had the opportunity to talk to many parents after transfer of five or six embryos, expecting now a high order multiple pregnancy. They never got any information about fetal reduction. They never believed something like that could happen. They do not know what is going to happen. They know that some fetuses will be killed. They want to know which one will be killed. This is a major problem for parents.”

Dr. Hugo Verhoeven: “What exactly is fetal reduction?”

Professor Manuel Carrapato: “Fetal reduction means that we are taking away one or two fetuses. Normally, we only consider fetal reduction if one of the fetuses is affected by an anomaly, a major abnormality incompatible with life.”

Dr. Hugo Verhoeven: “So you’re finishing the life of one of the multiples, realizing that this baby is fully normal.”

Professor Manuel Carrapato: “That’s right, but patients fail to understand to do fetal reduction
on absolute normal healthy fetuses at least at that stage. Reducing a abnormal baby is OK, but reducing a fully normal baby, that is a problem for these parents. As a neonatologist, another major problem is that not enough beds are available for preterm born babies. This is of course a problem of organization. But as we do not know exactly when the patient will deliver, we cannot allow a reservation of three or more beds during several months, just for the case the patient is delivering. Occasionally we do not have enough intensive care beds for these babies. It is not all that unusual that the babies need to be transferred to different places, and you end up with two babies in one place and the third or fourth elsewhere with all the consequences for the parents.”

**Dr. Hugo Verhoeven:** “Let us talk a little bit about costs. In many countries, even if the fertility treatment is paid by the patient herself, the costs for the care of the products or the success of the infertility treatment, the babies, who are maybe disabled, are going to be paid for by the community. I think this is an enormous amount of money that has to be covered by the social system. Is that correct?”

**Professor Manuel Carrapato:** “Absolutely, and very often, as you say, although the fertility treatment may be paid privately by the patients, in some countries it is in fact the taxpayer who is going to pay for the treatment of these tiny preterm babies who may or may not survive, and if they do, occasionally with severe disability. This is a major problem.”

**Dr. Hugo Verhoeven:** “Who should be responsible for the control of the use of these techniques? The government, ethical committees, or the individual doctor who is performing reproductive techniques?”

**Professor Manuel Carrapato:** “I don’t like the government taking care of this. I think we, as individuals and as professionals should be the one to be responsible for what we are doing, and I think that is very important.”

**Dr. Hugo Verhoeven:** “But it is my understanding that many doctors are ignoring the risks of their treatment because of financial reasons. They say - if my pregnancy rate is going down, my reputation is going down, I’ve fewer patients and less income, and I have to pay my personnel. So I think that’s also a very important thing.”

**Professor Manuel Carrapato:** “It may be, it shouldn’t be and, again, I think it’s a question of education, it’s a question of differentiation. I am convinced we really should be the one to regulate our own practice.”

**Dr. Hugo Verhoeven:** “This is a nice dream. I think others will have different opinions. I fully agree with you, but it will be very difficult to realize that. What I think is very important and will interest our readers and listeners certainly : what are the risks for the babies or let’s put it another way, what can the parents expect if they get multiple babies? Probably the delivery will be earlier than expected so the babies will be premature. Tell me about the risks for the baby and the parents.”

**Professor Manuel Carrapato:** “Risks are : the baby will be born prematurely with low birth weights, intrauterine growth restriction and therefore all the complications as related to prematurity and low birth weight: intraventricular hemorrhage, necrotizing enterocolitis, the whole spectrum of problems awaiting these babies and in the end perhaps either not surviving or if they do, with especially severe handicaps - mentally and psycho-motor problems, visual, hearing, learning difficulties, and this is in fact the whole spectrum of prematurity and extremely low birth weight babies, that’s the picture we’re talking about. The consequences for the individual, for the family, and for the society are enormous and that’s something again that we should all be thinking about.”

**Dr. Hugo Verhoeven:** “Do you have any idea of the incidence - if a baby is born as part of triplets in the 32nd week of pregnancy, for instance, what is the probability that this baby will have severe disabilities?”

**Professor Manuel Carrapato:** “If we are talking about triplets in the 30th week, that perhaps is not a major problem. What we’re really talking about are triplets or more born before 30 weeks and earlier in pregnancy. This is the group of babies with the highest risk and this is really the group of babies we really have to take care of. Please remember : Europe is not just the Europe of the
common market. The management of a singleton born before the 30th week can be in some countries a really big problem. All European countries have technical possibilities, in some countries these possibilities are minimal. In some European countries the survival of a tiny baby less than 22 weeks is still a major problem. In most of the European countries we now can, however, provide reasonable good figures for babies less than a 1,000 gram especially between 750-1,000 grams with good potential of survival. Unfortunately, not all European countries are in the same league and in some European countries the survival of a 25 or 26 week gestational age baby is still a major problem, either in terms of mortality or morbidity. This is for single pregnancies. If you’re talking about a multiple pregnancy, the problems are especially far more acute than when it’s just a tiny baby of a single pregnancy.”

**Dr. Hugo Verhoeven:** “So what is your message for the patients and what is your message for reproductive Endocrinologists?”

**Professor Manuel Carrapato:** “The message to the patients is that they should really think and think carefully before they go ahead with whatever assisted reproductive technique. They should be informed and they should decide for themselves whether or not it’s worth going ahead knowing the precise risks for their babies, and then evidently the doctors should counsel the patients in a totally unbiased, independent, and honest way. Whether finances have anything to do with it, I don’t think finances should come into medicine. I think the doctors should give a clear picture to the mother-to-be on what the consequences and risks are, and what the outcome of a multiple pregnancy is. This is the main risk of ART. I think this is primarily the doctors’ responsibility.”

**Dr. Hugo Verhoeven:** “This is one of the reasons for interviewing experts like you: to give patients and doctors the possibility to get more information. So thank you very much for giving me the pleasure.”

**Professor Manuel Carrapato:** “It’s been my pleasure, and I would really like to see this problem sorted out because it’s becoming a major universal problem. Thank you very much.”

**Dr. Hugo Verhoeven:** “A lot of success with this huge meeting and thank you very much once again.”

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