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Counseling Pregnant Women Who May Deliver Extremely Premature Infants: Medical Care Guidelines, Family Choices, and Neonatal Outcomes

Joseph W. Kaempf, MD, Mark W. Tomlinson, MD, Betty Campbell, RNC, Linda Ferguson, RNC, Valerie T. Stewart, PhD

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The authors have indicated they have no financial relationships relevant to this article to disclose.

What’s Known on This Subject
Resuscitation practices at the threshold of viability vary between institutions, often with no clear reason as to why. Cultural, moral, religious, and technological variables likely play a large but unspecified role in these differences.

What This Study Adds
Our institution has developed a consensus counseling process that uses specific recommendations for infant care at each gestational week combined with open discussion to promote informed parental choice. The effects of this process on neonatal survival and maternal sentiments is reported.

ABSTRACT

OBJECTIVES. The justification of neonatal intensive care for extremely premature infants is contentious and of considerable importance. The goal of this report is to describe our experience implementing consensus medical staff guidelines used for counseling pregnant women threatening extremely premature birth between 22\textsuperscript{0/7} and 26\textsuperscript{6/7} weeks’ postmenstrual age and to give an account of family preferences and the immediate outcome of their infants.

METHODS. Retrospective chart review was performed for all women threatening premature birth between 22\textsuperscript{0/7} and 26\textsuperscript{6/7} weeks postmenstrual age who presented to our high-risk obstetric service between June 2003 and December 2006. Women participated in comprehensive periviability counseling, which featured our specific obstetric and neonatology care recommendations for them and their infant at each gestational week. A subset of women were approached to obtain consent for a 2-step interview process beginning 3 days after the initial periviability counseling and followed with a 6- to 18-month assessment.

RESULTS. Two hundred sixty women were identified as eligible subjects. After periviability counseling, but before any birth, palliative comfort care was requested by a higher percentage of families at each decreasing week. Ninety-five of the 260 women delivered 121 infants at \textless 27 weeks’ postmenstrual age. At delivery, at the request of the families and with the agreement of the medical staff, the following proportions of these infants were provided palliative comfort care: 100% at 22 weeks, 61% at 23 weeks, 38% at 24 weeks, 17% at 25 weeks, and 0% at 26 weeks. All nonresuscitations and comfort care measures were supported by the medical and nursing staffs, and all infant deaths occurred within 171 minutes.

Fifty women consented to a postcounseling interview, and 25 of them also participated in a follow-up interview 6 to 18 months later. The counseling process and the guidelines were viewed as highly understandable, useful, consistent, and done in a comfortable manner. The tone and content of the parental comments regarding the counseling process were very positive, even more so at the later interview. There were no complaints or negative comments regarding the counseling process or the infant outcomes.

CONCLUSIONS. Rational, consensus periviability guidelines are well accepted and can be used by all neonatologists, obstetricians, and nurses who provide care to pregnant women and infants at extremely early gestational ages. Pregnant women see these guidelines as highly understandable, useful, consistent, and respectful. When encouraged to participate with attending staff in discussions involving morbidity and mortality outcomes of premature infants and consensus medical practice recommendations, a substantial proportion of parents will choose palliative comfort care for their extremely premature infant up through 25\textsuperscript{6/7} weeks’ postmenstrual age. We believe the choice of neonatal intensive care versus palliative comfort care in extremely premature infants rightfully belongs to medically informed parents. More research is needed to examine how these decisions are made under diverse conditions of culture, religion, and technology. Pediatrics 2009;123:1509–1515

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Key Words
extreme prematurity, medical counseling, palliative comfort care, infant resuscitation, periviability

Abbreviations
PMA—postmenstrual age
PSVMC—Providence St Vincent Medical Center

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PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275). Copyright © 2009 by the American Academy of Pediatrics
EXTREMELY PREMATURE BIRTH of <27 weeks’ postmenstrual age (PMA) presents enormous complexities for all to consider, especially for expectant families. Survival of these infants has dramatically increased since the 1980s, however, enthusiasm for this phenomenon is tempered by the long-term follow-up experience with these children. Despite a significant decline in mortality, neurodevelopmental injury rates remain high and do not seem to be consistently improving.1–3

Follow-up investigations of surviving infants born at <27 weeks’ PMA from a variety of institutions and populations demonstrate outcomes that seem to be remarkably consistent. Approximately 25% of infants suffer severe neurologic damage, 25% moderate impairment, and 50% are judged to be mildly impaired or normal.1–4,6,7 These investigations suggest the earlier the PMA, the higher the disability rate. Furthermore, “normal” surviving infants are at considerable risk for a variety of neurobehavioral, social, and educational deficits that likely reflect altered neurobiology related to prematurity birth.5,8 Although the same short- and long-term health outcomes data are available to all caregivers for counseling families, widely divergent practice styles have emerged regarding when mandatory neonatal intensive care is recommended.9–11

Because of the sheer number of extremely premature infants (~25 000 born per year in the United States), we must rationally address 4 vital issues. First, how do we best inform prospective parents as to the long-term health outcomes of extremely premature infants? Second, how do we collectively decide when the application of intensive care is or is not indicated? Third, how do we agree what is moral and ethical decision-making by physicians and surrogate decision makers (parents)? Fourth, how can we effectively study the periviability decision-making process with the goal of improving rational, compassionate, and responsible medical care?

The Providence St Vincent Medical Center (PSVMC) high-risk obstetric and neonatology service has developed and reported a consensus counseling process to at least partially address these essential questions.9 The purpose of this report is to (1) describe our experience with these guidelines and counseling process, (2) share the choices for neonatal intensive care or palliative comfort care that our families have made along with immediate neonatal outcomes, and (3) present follow-up survey information obtained from a subset of these pregnant women.

METHODS

Setting and Design
PSVMC is a tertiary referral center for both high-risk obstetric and level 3 NICU care. There are ~6000 deliveries and 800 admissions to the NICU per year, including ~35 infants born per year between 22 0/7 and 26 6/7 weeks’ PMA. PSVMC has created and implemented consensus medical staff periviability guidelines and counseling described in our previous report.7 These guidelines, containing specific obstetric and neonatology recommendations at each week PMA (Tables 1 and 2), form the framework for the consultation process among the family, obstetrician, and neonatologist.

This report is a retrospective chart analysis of all pregnant women admitted to labor and delivery between 22 0/7 and 26 6/7 weeks’ PMA from June 1, 2003 through December 31, 2006. Our periviability counseling process attempts to promote clarity, consistency, and a consensus outcomes data presentation as well as sharing specific recommendations for medical intervention. Our practice is participatory and individualized, thus physicians could provide counsel that did not agree with the consensus guidelines depending on individual clinical circumstances such as fetal gender, growth restriction, multiple fetuses, and antenatal betamethasone use. Similarly, families were encouraged to engage in the decision process. After we provided parents with succinct outcomes data and medical care options the parents would provide us with their individual preferences on the basis of their own cultural tenets, moral values, and/or religious convictions. All clinicians agreed to provide the consensus medical staff guidelines in written form to the family, regardless of individual physician or family preferences. If there was disagreement between the recommendations of the physicians and the preferences of the family, after full consultation and open dialogue, the wishes of the family became the basis of the medical care plan.

Our chart review recorded the woman’s/family’s preference for NICU care or comfort care both at the time of completion of the initial consultation as well as at the actual time of birth (if it was <27 weeks’ PMA). NICU care meant full resuscitation with institution of nasal continuous positive airway pressure or mechanical ventilation, administration of medications, and/or placement of central vascular catheters as indicated. Comfort care was a palliative process of minimal medical intervention toward the infant, emphasizing warmth, presence with the parents in a quiet private room, and no medications or procedures. At PSVMC, the decision to proceed with NICU care versus comfort care is not determined at the time of delivery on the basis of the

| TABLE 1 | PSVMC Survival and Neurologic Disability Rates in Extremely Premature Infants |
|---------------------------------|------------------|------------------|------------------|-----------------|------------------|
| Weeks at Birth (PMA)            | VON 2004 Inborn Survival Rate, % | PSVMC 2000–2004 Inborn Survival Rate, % | Severe Neurologic Disability (Literature Survey), % | Moderate Neurologic Disability (Literature Survey), % |
| <23                             | 4                 | 0                | —                | —               | —                |
| 23%–23%                         | 27                | 5                | —                | —                | —                |
| 24%–24%                         | 56                | 68               | —                | —                | —                |
| 25%–25%                         | 74                | 73               | —                | —                | —                |
| 26%–26%                         | 84                | 83               | —                | —                | —                |

Disability estimates are contained in references 1, 2, 4–9, 24, 25. VON indicates Vermont Oxford Network.

a Severe disability: mental developmental IQ of <70 or >2 SDs below the mean, and/or cerebral palsy, and/or blind, and/or deaf.
b Moderate disability: mental developmental IQ of 70–84 or 1–2 SDs below the mean, Morbidity disorders of motor skills, vision, hearing, academic achievement, social performance, and/or behavior included in some follow-up references.
response to bag/mask ventilation and/or the Apgar scores.

In addition, a prospective analysis was performed from August 21, 2003, through September 30, 2004, in a subset of pregnant women who agreed to a postcounseling interview designed to assess their perception and comprehension of the consultation process. The patient survey was administered 3 to 4 days after the initial medical consultation by a labor and delivery ward secretary not involved with patient care. The women were then contacted by telephone 6 to 18 months after the initial periviability consultation and given the same interview again to see if perceptions and sentiments had changed. Each interviewer was trained in standard interviewing techniques, including open-ended question delivery and probing without leading. Analysis was blinded with respect to patient identifiers. Institutional review board approval was obtained for the investigation.

**Statistical Analysis**

Likert scale answers and valence scores for open-ended responses were used to compare the immediate and long-term maternal interviews. Average scores were treated as continuous variables using the Student’s *t* test. Discrete response categories were analyzed comparing proportions within each response at each interview by using *χ²* analyses to test for differences in proportions.

**RESULTS**

Figure 1 displays a summary of the pregnant women admitted to our high-risk obstetric unit during the study period of June 1, 2003, through December 31, 2006. There were a total of 806 antenatal admissions between 22 2/7 and 26 6/7 weeks’ PMA. Of these, 482 were for reasons other than threatened premature birth. This left 324 admissions with potential extremely premature birth. Sixty-four of these admissions were excluded from analysis, because they did not receive formal periviability consultation. This was principally because 62 of these women were 25 2/7 to 26 6/7 weeks in advanced labor with the immediate (and sometimes emergent) indication from the family at the outset that they desired full NICU care, and/or because the physicians were not comfortable with palliative comfort care in a setting where time constraints limited the full counseling process. The mean age (SD) of the women was 29 (6) years and 43% were nulliparous.

Table 3 demonstrates the neonatal care preferences of the women (families) after our initial guidelines-based counseling process was completed but before the actual birth of the infant. More women (families) requested palliative comfort care as the gestational age decreased. The proportion of women who could not come to a firm initial decision showed minimal variation week to week.

**TABLE 2** PSVMC Medical Staff Guidelines for the Care of Extremely Early Gestation Pregnancies and Extremely Premature Infants

<table>
<thead>
<tr>
<th>Weeks at Birth (PMA)</th>
<th>Obstetric Care</th>
<th>Neonatal Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;23</td>
<td>Tocolysis as indicated</td>
<td>NICU care not offered</td>
</tr>
<tr>
<td></td>
<td>No steroids</td>
<td>Comfort care provided</td>
</tr>
<tr>
<td>23%–23%</td>
<td>Tocolysis as indicated</td>
<td>NICU care not recommended because of high mortality and high</td>
</tr>
<tr>
<td></td>
<td>Steroids not recommended</td>
<td>neurologic disability rate</td>
</tr>
<tr>
<td></td>
<td>Cesarean delivery for fetal indications not recommended</td>
<td>Comfort care provided</td>
</tr>
<tr>
<td>24%–24%</td>
<td>Tocolysis as indicated</td>
<td>NICU care may be declined and comfort care provided, or NICU care may be</td>
</tr>
<tr>
<td></td>
<td>Steroid use if mother/family choosing NICU care at &lt;26 wk</td>
<td>chosen by the mother/family after review with the medical staff of the</td>
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<tr>
<td></td>
<td>Cesarean delivery may be declined or chosen after review of</td>
<td>probable and potential clinical outcomes</td>
</tr>
<tr>
<td></td>
<td>clinical outcomes</td>
<td>Majority of medical staff does not recommend NICU care</td>
</tr>
<tr>
<td>25%–25%</td>
<td>Tocolysis as indicated</td>
<td>NICU care may be declined and comfort care provided, or NICU care may be</td>
</tr>
<tr>
<td></td>
<td>Steroid use if mother/family choosing NICU care at &lt;26 wk</td>
<td>chosen by the mother/family after review with the medical staff of the</td>
</tr>
<tr>
<td></td>
<td>Cesarean delivery may be declined or chosen after review of</td>
<td>probable and potential clinical outcomes</td>
</tr>
<tr>
<td></td>
<td>clinical outcomes</td>
<td>Majority of medical staff does recommend NICU care</td>
</tr>
<tr>
<td>26%–26%</td>
<td>Tocolysis as indicated</td>
<td>NICU care provided in the majority of cases</td>
</tr>
<tr>
<td></td>
<td>Steroids as indicated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cesarean delivery for fetal indications strongly recommended</td>
<td></td>
</tr>
</tbody>
</table>

Pregnant women admitted at 22% to 26% wk PMA

Jun 1, 2003, through Dec 31, 2006

- 806
- 324 potential premature birth
- 260 periviability consults
- 95 women/121 infants delivered at <27% wk PMA
- 64 no formal consult
  - NICU care asked for immediately in 62 (25%–26% wk)
  - 2 extremely preterm (<23 wk) or anomaly

FIGURE 1
Summary of all pregnant women 22% to 26% weeks’ PMA admitted to PSVMC during the study period.
Table 4 summarizes the postcounseling decisions for the 95 women (families) who actually delivered 121 infants (26 twin births) between 22½ and 26½ weeks’ PMA. Again, more women (families) requested palliative comfort care as the gestational age decreased. At no time did the physicians alter the decision of the women (families) on the basis of the response to bag/mask ventilation or the Apgar scores. All 37 infants provided comfort care died within 5 to 171 minutes; the median time of death was 60 minutes. None of the infants whose parents chose comfort care were given medications or subject to procedures. Infants who lived beyond 30 to 60 minutes had low heart rates with sporadic breaths before death. The survival rates in Table 1 are based on our inborn data from 2000 through 2004, a period before full implementation of our formal guideline counseling. Table 4 shows data from the study period (June 1, 2003, through December 31, 2006) and demonstrates decreased survival at 24 weeks’ PMA, no change at 25 weeks’ PMA, and an increase in survival at 26 weeks’ PMA.

Table 5 summarizes the interview results of the subset of 50 women who consented to a 3-day interview to assess the reaction to our counseling. The process was viewed as highly understandable, useful, and consistent. The women felt comfortable asking the physicians and nurses questions about both obstetric and neonatal issues. Ninety percent (45 of 50 women) indicated they were given enough information to make difficult life support decisions.

We attempted to reinterview the same 50 women 6 to 18 months after the initial encounter to assess whether their sentiments had changed. Fifteen of the women were unable to be interviewed because of relocation, changed telephone numbers, or failure to answer telephone messages. Of these 15 women, 10 chose resuscitation for their infant (3 subsequently died in the NICU), and 5 chose comfort care for their infant. Ten women declined the second interview (8 at the time of the first interview, 2 on follow-up contact). Eight of these 10 women who declined had infants who died (4 comfort care, 4 resuscitated but died in the NICU). Two of the 25 women who consented to the second interview had infants who were resuscitated but died in the NICU, the infants of the remaining 23 mothers all survived. Table 6 summarizes the interview results of the 25 women who consented to the second query. The results were very similar to the 3-day interview.

At both interviews open-ended questions were asked to measure evaluative valence of the comments (positive, neutral, or negative). Maternal sentiments were overwhelmingly positive regarding the conduct and content of the periviability counseling. $\chi^2$ analysis demonstrated a significant shift toward even more positive...
comments with the passage of time ($P < .0001$). At the first interview, 60% of the mothers specifically mentioned the medical care guidelines (Tables 1 and 2) as the most useful information given to them during the counseling process, and 72% made a similar comment at the second interview. A comparison of the 25 women who had 1 interview versus the 25 women who were interviewed twice showed no significant difference in the valence coding at the first interview.

DISCUSSION

For the sole purpose of promoting rational discussion, responsibility, and process improvement in a realm highly contentious, the PSVMC high-risk obstetric and NICU service published our experience formulating medical staff guidelines to counsel pregnant women threatening extremely premature birth. This follow-up article describes the impact of these guidelines and counseling on parental decisions regarding NICU care versus palliative comfort care for the extremely premature infant. Our major findings are: (1) the guidelines and counseling are well accepted and viewed as understandable, consistent, and helpful; (2) if given the informed opportunity, a substantial proportion of families will decline NICU care and choose palliative comfort care for their infant, even through 25/7 weeks’ PMA; and (3) the process of nonresuscitation and comfort care of extremely premature infants can be performed respectfully and with mutual understanding.

Bioethicists and health care providers widely recognize parents as the proper surrogate medical decision makers for their infants. It is difficult for parents to make rational, responsible decisions about medical care without some understanding of complex medical outcomes data. The process of information exchange and dialogue is often carried out in a maelstrom of cultural and religious diversity, physical stress, confusing technologic concepts, and the fundamental human desire for offspring. How to best deliver this complex information clearly needs more scrutiny.

Is there a predefined limit of gestational age below which we should not offer NICU care or above which NICU care should be mandatory? Recent comprehensive reviews suggest there to be no such absolute medical, moral, or legal standards. Surveys of neonatologists to determine when they individually feel NICU care is appropriate are problematic sources of guidance, because they lack consensus review of NICU outcomes and long-term morbidities, discussion of bioethical decision-making, and inclusion of participants beyond physicians. The majority of neonatologists seem to agree that NICU care at 26/7 weeks’ PMA or more is highly advisable (even mandatory), but that compulsory NICU care below 24/7 weeks is viewed as unreasonable or inadvisable by most.

At PSVMC, we do not recommend NICU care for infants born at <25/7 weeks’ PMA, principally because (1) the chance of NICU death or significant neurologic injury is generally 50% or more, and (2) our providers believe it neither reasonable nor fair to insist on resuscitation of infants who may have enormous long-term health issues that we may not help the family cope with or resolve. Our estimations of death or significant neurologic injury at each week of gestation are in reasonable agreement with the recently published Neonatal Research Group calculator estimates. We do include gender, growth restriction, multiple fetuses, and antenatal betamethasone use into our discussions of mortality and morbidity. How each of these risk factors affected parental decisions was not measured.

We recognize the tremendous cultural and religious diversity that influences what families consider to be moral decision-making. Families are encouraged to agree or disagree with our recommendations in a decision-making process that is collaborative. Parents do change their initial inclinations regarding resuscitation. Tables 3 and 4 show that some women at each gestational age switch their initial preference as to resuscitation versus comfort care. We did not override any initial preference but do think our guidelines and open discussion influenced their choices. We do think the trend toward lower survival rates at 23 and 24 weeks (Table 4 compared with Table 1) is a result of our counseling and guidelines. Our 23-week survival rate is average, and our 26-week survival rate is extraordinarily high.

### Table 6 Postconsultation (6- to 18-Month) Maternal Interview Questionnaire

<table>
<thead>
<tr>
<th>Questions</th>
<th>Responses, n (%)</th>
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<tbody>
<tr>
<td>How much did you understand from the doctors about the premature baby?</td>
<td>All of it 22 (88), Some of it 3 (12), None of it 0 (0)</td>
</tr>
<tr>
<td>How useful was the information given by the doctors?</td>
<td>Extremely useful 18 (72), Somewhat useful 6 (24), Not very useful 1 (4)</td>
</tr>
<tr>
<td>Did you get the same information from the doctors and nurses?</td>
<td>Yes 24 (96), No 1 (4)</td>
</tr>
<tr>
<td>How comfortable were you asking the doctors about the risks of delivery?</td>
<td>Very comfortable 21 (84), Somewhat comfortable 3 (12), Not comfortable 0 (0), Don’t remember discussion 1 (4)</td>
</tr>
<tr>
<td>How comfortable were you asking questions of the nurses?</td>
<td>Very comfortable 21 (84), Somewhat comfortable 3 (12), Not comfortable 0 (0), No response 1 (4)</td>
</tr>
<tr>
<td>Pick the description that best describes your situation.</td>
<td>I had to make a tough decision, I was given enough information, and feel good about it 15 (60), I had to make a tough decision, I was given enough information, and I feel bad (worried) about it 4 (16), I had to make a tough decision, I was not given enough information, and I feel good about it 1 (4), I had to make a tough decision, I was not given enough information, and I feel bad (worried) about it 0 (0), No response 5 (20)</td>
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After discussion and informed consent, we will provide NICU care at <25% weeks' PMA if families so choose, but not below 23% weeks. We recommend NICU care at 25%-27% weeks or more, but will offer comfort care up to 25% weeks if the families so choose. It is our contention that there is no medical, moral, or legal mandate to resuscitate extremely premature infants <26% weeks against parental wishes. It has not been convincingly demonstrated that 26-week infants have superior neurodevelopmental outcomes compared with 25-week infants, 25 weeks compared with 24 weeks, or 24 weeks compared with 23 weeks,1,4,6,24,25 thus making a mandatory resuscitation policy at a specific gestational age problematic, even illogical. We wonder if the use of the term “gray zone” should be abandoned, as it implies we have determined medical and moral certainty, “black and white zones” if you will, at other precise gestational ages. We do not support the practice of making life support decisions while the neonatologist evaluates the premature infant (and his/her response to resuscitation), because using the initial appearance of the infant will not reliably correlate with longer-term outcomes.26 Our periviability counseling process (Fig 2) is well within the framework of the recent American Academy of Pediatrics statement11 and comprehensive reviews of neonatal bioethics,12,17,21,27,28 perhaps just more specific.

It is important to emphasize that we have not experienced a single documented objection or complaint from any woman or family member who has gone through the counseling process, whether they chose NICU care or palliative comfort care. Table 5 highlights the generally positive opinions 50 women had of our counseling process, seen as understandable, useful, consistent, and done in a comfortable manner. We recognize the limitations of obtaining only 25 longer-term interviews (Table 6), and do note all 25 women elected to resuscitate their infants. This could conceivably influence their sentiments regarding our counseling. However, the valence coding of the 25 women interviewed once did not differ from those 25 women interviewed twice, and the counseling process was viewed even more positively with the passage of time. Also notable was the fact that the majority of women at both interviews mentioned the consensus medical staff guidelines as the most useful information given to them to help them decide whether they wanted NICU care or comfort care for their infant.

Like others, our NICU functions in a culturally diverse environment. The health care providers and family at any given bedside might be composed of Christians, Jews, Hindus, Muslims, and/or nontheists. The content of participant moral standards varies widely. Religious or faith-based beliefs that conflict are particularly difficult to resolve, because their foundation is not strictly evidence-based and thus difficult to scrutinize in a way that all participants would view as comfortable or rational. For reasons unclear to us, this complexity receives little critique in the NICU literature. The contention (based on the conduct of history) that moral standards are entirely of human creation is a strong one. What is judged as right or wrong is subject to every manner of cultural influence and social construction.29–32 The uncertainty and discomfort with this peculiar admixture can lead to life support decisions defaulting to the medical experts (neonatologists) and our most expedient option, NICU care.33 Physicians, in obvious positions of power and authority, are prone to frame the controversy in medical, scientific, or even legal terms, conditions in which we believe we are well-versed. The appropriate care of extremely premature infants is perhaps better approached as a combination moral, social, and scientific issue, one in which we as physicians can easily be out of our comfort zone and have no more legitimate authority than the family.

Our collaborative model of decision-making emphasizes inclusion of families and their sensibilities and rational analysis of evidence and options, all discussed in a spirit of fairness and compassion. We believe our model of consensus recommendations with ultimate trust placed in parental choice is both reasonable and just, a negotiated best-interest model11 that is preferable to expertise best-interest models.10,28

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STUDENT EXPECTATIONS SEEN AS CAUSING GRADE DISPUTES

“Prof. Marshall Grossman has come to expect complaints whenever he returns graded papers in his English classes at the University of Maryland. ‘Many students come in with the conviction that they’ve worked hard and deserve a higher mark, Professor Grossman said. ‘Some assert that they have never gotten a grade as low as this before.’ He attributes those complaints to his students’ sense of entitlement. ‘I tell my classes that if they just do what they are supposed to do and meet the standard requirements, that they will earn a C,’ he said. ‘That is the default grade. They see the default grade as an A.’ A recent study by researchers at the University of California, Irvine, found that a third of students surveyed said that they expected B’s just for attending lectures, and 40% said they deserved a B for completing the required reading. ‘I noticed an increased sense of entitlement in my students and wanted to discover what was causing it,’ said Ellen Greenberger, the lead author of the study, called ‘Self-Entitled College Students: Contributions of Personality, Parenting, and Motivational Factors,’ which appeared last year in *The Journal of Youth and Adolescence*.”

Noted by JFL, MD
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