

Quandary

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at a baby for 12 hours a day, we can see... Being able to pick up on something soon, that's the key to taking care of babies of this size," said unit nurse Marie Kuznicki of Clawson.

"It's nowhere near the problem it used to be," said Kelly, adding that it is still a problem with some patients.

Few danger signs

Estimates aside, Kelly stressed that the onset of premature delivery often isn't predictable, either for mothers or physicians. And that certainly applies in cases where babies are born as early as 23 weeks.

"It's hard to know," Kelly said. "Usually, you start finding out about it when the patient calls up and say 'I'm having all of these contractions.' Usually, in prenatal care, there are not a lot of signs to tell you you're going to deliver between 23 and 27 weeks."

Often, this kind of premature labor takes place in pregnancies that are going well. Everything's fine, until the woman starts to feel contractions are getting stronger and stronger," Kelly added.

Sometimes, mothers develop serious health problems of their own, such as toxemia, which

prompt emergency Caesarean sections. Other times there is no warning about what might occur.

"We do try to stop the labor and keep the pregnancy going," Kelly said. "(But) if the baby's right there in the birth canal there's nothing you can do to stop delivery."

Signs of premature labor aren't always absent. For example, in some cases, the cervix starts to open up and thin out and/or the uterine wall becomes thinner, he said.

Every day helps

Meanwhile, doing whatever that can be done to prolong pregnancies is crucial to the viability of very low-birth-weight infants.

Injecting steroids to quicken lung development, and reduce instances of bleeding in the brain, is a recent positive development for perinatal medicine, Kelly said. Every day a fetus stays in the womb increases chances of survival.

So, knowing the gestational age is a key piece of information, particularly since 25 weeks is the line drawn in the sand by some doctors about how aggressively to treat micropremies — Michaels among them.

For a 23-week baby without hope of surviving intact, Michaels said he would "not do anything but keep it warm and comfortable."

"(At) 24 weeks I'd do nothing more... The closer you get to 25 weeks the more careful you have to become, because you've pushed the viability to that point with technology, the more difficult it becomes in not recommending aggressive treatment."

Compounding that dilemma is the uncertainty over gestational age, which means a baby thought to be 25 weeks old might be as young as 23 weeks.

That's why Michaels is uncomfortable about the notion of "Playing God In The Nursery," the title of a book he pulled off his office shelf.

He said the border of viability has changed since 1980, so much so that doctors today decide to intervene on behalf of a 24- or 25-weeker when those infants wouldn't have survived 15 years ago.

What they look for

Maximum efforts are made, Michaels emphasized, "knowing that — for those who survive — a significant percentage will not

survive intact.

"For the ones who do survive and do well, in a broad sense it can make it all worth it. But just talk to the families who have a very seriously handicapped child because of premature birth," Michaels said.

Kelly estimated that 99 percent of babies born at 23 weeks or younger do not survive.

"In most cases they just put the baby in a warmer in the NICU and wait for the baby to die," Kelly said. "If it's a 24-weeker who looked bad they'd do the same. But if it's a 24-weeker who looked good, they would do everything to save that baby."

Neonatologists, those physicians who treat infants immediately after they are born, first examine the general condition of a baby. That entails looking at how fused the eyes are, size of the baby and how well the baby is breathing.

"So the (neonatologist) has to put it all together and decide, 'Is it possible that I can give this baby some reasonable existence should the baby survive?' And that's a decision that takes years of experience," not one hastily made, Kelly said.

Although Michaels' personal

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opinion about which babies to aggressively treat appears inflexible on the surface, the doctor insists he cheers for the youngest micropremies to survive intact and bases his point of view on years of experience.

About Messenger

"The sanctity of life is very important to me," Michaels said. "I personally don't have a cause. I have a humanistic approach. I've seen extraordinary successes and I've seen significant difficulties arise. And I've seen families succeed and families fall apart because of this."

Meanwhile, Michaels also said something good could come out of the public debate sparked over the past year by Michigan dermatologist Gregory Messanger's decision to withdraw life support from his own 25-week child and the subsequent trial, where he was found innocent of wrongdoing.

"I think actually, the publicity and the trial, although viewed by some as negative, was actually positive because it provoked discussion about a difficult issue and raised public awareness," Michaels said. "... But when you withdraw life support from a child, it evokes all kinds of emotions. I think that's why it was so negative. I view it as sad... because we can't resolve all potential difficulties of future life for the extremely premature."

According to Michaels, the bottom line of the whole debate is "Society has to decide how (it's) going to pay for the care of these children who have difficult problems and support families to which these children are born. We need to be realistic. The negativity here is the act was performed by the parents themselves."

Touch

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But Cain and other unit nurses said their job is as rewarding as it is challenging, particularly when they see healthy ex-micropremies who cared for months after their discharge.

"I'm just so excited and so overwhelmed," Cain said. "To think that this little tiny thing is now a 'baby.' It looks like a baby and reacts like a baby and the parents are confident with it. And just to watch the baby reacting to the parents talking and touching. It's just overwhelming."

Jennifer Andres, another NICU nurse, called it "just amazing how they develop their personalities... When they're there for four or five months, you really know what their personalities are like and you know what little quirks work with them."

Andres, a Troy resident, added that, when parents bring their babies back for the premie reunion picnic, it's hard not to "boast and

say 'I had a part in that, I helped care for that baby.'"

Helping them cope

For those few-and-far-between moments of reward, NICU nurses put in long, grueling hours, always prepared for emergencies and uncertainty. Those demands are realities of the game they willingly entered — the medical fight to save premies and micropremies.

"The reason I'm in neonatology is I'm interested in the challenges that these babies are constantly giving us," Andres emphasized. "They don't give you the cues of a normal child. They can't verbally express 'I need this' or 'I need that.' So, you have to learn how to read people's cues and babies' cues. And they can turn very critically on a dime."

Another thing that can rapidly change is the emotional state of family members. In NICU's, nurses are part psychologist.

For example, Andres said some parents and grandparents might not visit the hospital, not wanting to become emotionally attached to babies they fear will not make it.

"They're afraid of loving their baby, and that's what the nurse is there to do," Andres said. "To try and help bridge over that denial and say 'Touch your baby, your baby knows it's you.' And you have to do that very gently."

Knowing how to approach families about their babies is another crucial challenge faced by NICU nurses, Kuznicki said. "Every family is so different," she said. "So you see the coping mechanisms and try to assess them."

Kangaroo care

Kuznicki elaborated on that point. "Our goal in the NICU is to... provide support to the family as well as to the baby. And, as long as one of (the two) isn't

healthy, then we still have challenges. The parents have to be able to cope and to learn and to accept their baby."

A technique known as "kangaroo care," or skin-to-skin, is making inroads — both at Beaumont and Providence — as a way to help parents bond with their micropremies.

"We do kangaroo care, we encourage it with mothers and fathers," said Linda Omstead, NICU nurse manager at Providence. "The best way to keep the baby warm and encourage bonding is skin-to-skin."

Omstead said benefits of kan-

garoo care include improved color and a slower respiratory rate. "It's a comforting measure, not just for the baby, but for the parents, too."

Farmington Hills resident Lora Volpe would attest to that. Her 2-pound 13-ounce premie daughter Andrea, a 26-weeker born in March 1993 at Providence, was the first to benefit from the technique at that hospital. Andrea today is a bubbly 2-year-old.

"I feel it was really, really important to do it," Lora Volpe said. "I'm her mother. I wanted to hold her so bad and do some bonding with her... It was just a wonderful feeling to hold her."

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