William D. Grant, EdD
Feature Editor

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A Birth Crisis

Margaret R.H. Nusbaum, DO, MPH; Margaret R. Helton, MD

Peering over the shoulder of my resident, I supervise her delivery of a baby. She is confident and competent and deftly cuts the tight nuchal cord and relieves a mild shoulder dystocia. We have been observing this labor for several hours, perhaps with a bit more concern than usual since the fetal monitoring shows a baseline heart rate with little variability and no accelerations. But, the mother's labor progress has been steady, and we look forward to delivering the baby into the expectant hands of the parents. However, after clamping the cord, the baby shows no respiratory effort, and no pulse is felt, despite the fact that fetal heart tones were heard moments before delivery. I swiftly hand the lifeless little body over to the helping hands of the neonatal team. My first update to the family is what I have said many times before, often with my back to the family, resuscitating the baby myself, "We're just trying to get your baby to cry." But the baby does not cry and does not even establish a heart beat, despite valiant efforts on the part of the neonatal team. Like a mother bird, I carry updates, piece by piece, back to the family, building a nest of information meant to cradle the final fragile words, "I am sorry. We did everything we could." Her cry of anguish cuts through the palpably fear-filled room, signaling the onset of grief, for her, her family, and her health care team.

Despite having delivered babies for nearly 20 years, I did not see this coming. Still, I maintain my professionalism and shift to triage mode for a birth crisis, prioritizing first the family, then the resident, and finally the health care team. As attending physician, I remain lowest priority. The chaplain arrives as I bundle the perfect-looking little body. Carrying the child back to his mother, I cradle him carefully, perceiving him as more delicate and requiring more caution than a healthy, screaming newborn. I gently hand him to her.

I am well schooled to never hide my own tears from families in such circumstances, but feeling that I needed to handle the situation for the family and the resident, I initiate a birth crisis review and focus on the paperwork. My resident colleague is shedding the tears for me, our team, and for the family. This is her first experience with such tragedy, and I take some consolation in knowing that it is better for her to have her first such experience under the umbrella of residency training rather than alone in her practice. Later, as I hug her, I feel her wrap her arms around herself as if protecting her own gravid abdomen from some unknown danger.

Healing begins as the family holds the little body, inspecting his face, fingers, and toes, and saying his name aloud. The mother thanks me for all we did, asking that we join in for the blessing, a moment of beauty nestled inside a tragedy.

I began the usual course of review. Is there anything we could have done differently? Having seen the end of life initiated at cord clamping before, I suspect anomalies incompatible with life, an idea further supported by a relatively acceptable cord pH. Reviewing the entire prenatal, labor, and delivery process, I find nothing I would have done differently. I share the fact that I do not know what happened with

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From the Department of Family Medicine, University of North Carolina, Chapel Hill.

the family and the team. I meet with the nursing staff and speak briefly with the neonatologist. In an effort to be collegial, I update the obstetrician staffing the labor and delivery unit and find him squirming in his chair and avoiding eye contact. I have no doubt that he believes this would not have happened had the baby been managed by him or one of his obstetric colleagues. I hold my head high and explain to him that I suspect some sort of anomaly, incompatible with life. He senses safer ground here and turns toward me and recites neonatal conditions that might make resusitation impossible. We part with an understanding that we need to wait on further data from the autopsy.

When I reach home, my husband knows exactly what to do as the words leave my lips, "I had a baby die today." He has been there before and is skilled in his support but still wonders why I continue to deliver babies as part of my practice.

The next day, I awake early, unaware of the day's perils. I was unprepared for the assault that was about to take place. For the next 48 hours, I experienced feelings similar to those reported by women who have been raped. There is the trauma from the event itself but then the system assaults further, leaving deep emotional scars.

Perhaps it is my clothes that have set me up. The rape victim takes her usual route, wears her usual clothes, and is often raped by someone she knows and trusts. As a family physician, the clothes I wear and the road I walk involves a choice to deliver babies. I deliver babies in a system I have known for nearly 7 years, and I am confident of my skills (there is nothing unusual about this walk for me). The obstetrical nurses have assured me of their confidence in my management (I am in a familiar neighborhood). Thus, I did not recognize the first perpetrators. Without my knowledge, several nurses brought the fetal monitor strip (my clothes) to the obstetrician. They want assurance, which they receive, that had he been managing the case, he would have performed a cesarean section, and this would not have happened. Fueled by such words, other nurses join the process, and what feels to me like a gang rape unfolds. A nursing administrator interrogates me and questions my understanding of fetal monitoring, labor management, and the consultative process. The rape victim hears, "You are a young, attractive woman. Why would you walk alone?" I am hearing, "You are a family physician. Why didn't you consult an obstetrician?" I explain that besides decreased variability on the fetal monitoring strip, there was nothing in the course of labor and delivery to suggest such a bad outcome. Still, she persists with an accusatory tone, and the words pummel me. I am shocked that a nurse administrator sees this interrogation as part of her job. Just as an interrogator asks a rape victim, "Why did you walk alone?" the repeated question "Why didn't you ask for an obstetrical consult?" implies that the baby's death could have been prevented and that I am to blame.

A nurse mentions to me that she feels uncomfortable working outside of her area of labor and delivery, suggesting that delivering babies is not an area for family physicians, a statement calling into question the competency of the entire specialty of family practice. Another nurse explains that she should have spoken more forcefully about her concerns at the time that the lack of fetal heart variability was discussed, as if it was obvious to everyone else that this was going to happen. My resident colleague and I feel that people turn and stare as we keep working on labor and delivery, now managing another patient in labor. We are not even sure who to talk to, as eyes are diverted and whispers occur.

Nurses who I had previously trusted (friends who the rape victim turns to), say that they do not want to work with family physicians anymore. If I had not walked alone, not worn the clothes I did, not been as friendly as I am, this rape, this preventable tragedy, would not have occurred. I am now dirty and disgusting. If they associate with me, they might get raped themselves.

The assault continues. They say they don't want to work with me because they believe that because of the way I look (young), act (nice), walk (by myself as a confident, competent family physician) that this will surely happen again and again. I try hard to reframe this behavior as a need to place blame and shame so the tragedy can be accepted. Perhaps this event threatened their sense of competency or job security. Perhaps this behavior is just immature coping skills and means of self-protection. My resident colleague holds close to her heart the words of an obstetrical resident who takes her aside and advises her, "Don't listen to what people are saying," kind words of support, whispered by someone who cannot share this publicly without ridicule.

As a teacher in a residency program, I include my resident colleague in this experience, even though it is painful and abusive. I know she needs to be strong and confident and hope she is developing resilience. I have seen physicians quit some aspect of their clinical practice because of this treatment, most notably around delivering babies. I hate to think that the women in the rural town where she is going to practice, where no obstetrician will venture, might lose a skilled physician because of such abuse.

Through this all, my resident colleague and I maintain our relationship with the most important people in this situation—the mother and the family. We tell each other that no matter what is happening to us, we must be there for the family.

My family physician colleagues are saddened and upset when they see the data from the case with their own eyes, having heard gross exaggerations of the facts. As their

eyes fill with tears, hearing what I have been through, it is the first time in more than 48 hours that I am able to see who my real friends are. I feel support and encouragement in grieving the two tragedies: a neonatal death and a rape by the system.

What if I had made an error in judgment? I am in a high-risk profession with long hours, chronic sleep deprivation, and ever-changing medical information. There are many degrees of error—from making a minor mistake in writing a prescription to making a judgment that contributes to patient injury or death. In 1999, the Institute of Medicine created the Committee on the Quality of Health Care in America, which released the report *To Err Is Human: Building a Safer Health System.*[1] This report received a lot of press attention since it highlighted concerns about patient safety. The same committee has recently released a second report, *Crossing the Quality Chasm: A New Health System for the 21st Century,*[2] which offers suggestions for redesigning the health care system so that it better meets the needs of the people it serves. In the report, they list 10 rules for the 21st-century health care system. One of the rules suggests that one of the biggest challenges to moving toward a safer health system is changing the culture from one of blaming individuals for errors to one in which errors are treated not as personal failures but as opportunities to improve the system and prevent harm. In other words, the "blame and shame" culture under which most of our doctors and nurses trained has no role in the modern health care system. It ravages the people working in the system and does little to improve patient care.

I report this rape not for retribution but as a case from which to learn. I hope we, the health care system, can step back and look at our behavior toward each other and work to improve the climate in which we work.

As time has passed, I find myself able to step back from the emotional drama of being accused of a wrongful death. Interactions on labor and delivery have reverted to usual. As part of my learning from this case, I have considered the wisdom advised in a book on personal growth:[3]

(1) *Be impeccable with your words*. Despite the emotional drama and the rush to persecution that occurred the day after this birth crisis, I remained confident that there was nothing I could have done to alter this outcome, and I did not seek to find someone else who I could blame. I felt I had been honest with what had occurred.

(2) *Don't take anything personally.* I did not do well with this. I did take the accusations of a wrongful death personally, and I was shocked to hear from the nursing administrator that the nurses' recount of the events prior to delivery was contradictory to mine. Perhaps the nurses were acting out of self-preservation, as was the nursing administrator, but clearly the blame was placed squarely on me. I took the words personally, as an insult to my integrity and competency.

(3) *Don't make assumptions.* I made assumptions that the accusations the nurse administrator was confronting me with were directly from the mouths of the nurses involved in the case. In speaking with the nurses later, I discovered this was not completely accurate. When emotions are high, and rumors are flying, it is not uncommon to hear something that is once or twice removed from the original source.

(4) *Always do your best.* This is all I can ever do, but I'll try to do even better next time.

The epilogue to my story is that at autopsy this little boy was found to have Pompe's disease, a glycogen storage disease that had left depositions in his heart, liver, lungs, and other tissues. The findings were incompatible with life, confirming that no course of action during the labor and delivery process would have led to a different outcome. I cannot hide the fact that I feel some relief, but I know there may be future outcomes without such vindication. I understand that we cannot completely eliminate bad outcomes, but I harbor hope that perhaps we can avoid assaulting the people who work in the health care system. A supportive environment will help us create the system that will serve our patients best as we seek to improve health care systems in the 21st century.

Addendum

Our department began addressing this case as a sentinel event for beginning a Continuous Quality Improvement (CQI) discussion on how we could all have handled the process better. The family, physicians, nurses, and staff are appropriately grieving. The physicians, nurses, and staff have gone on to handle subsequent perinatal losses: wanted early gestations gone awry, neonatal complications, malformations, stillbirths. Our residency program graduate continues to provide prenatal care and deliver babies for women in a rural, underserved area. She is an excellent family physician and a wonderful parent.

Correspondence: Address correspondence to Dr Nusbaum, University of North Carolina, Chapel Hill, Department of Family Medicine, 101 Manning Drive, CB 7595, Chapel Hill, NC 27599-7595. 919-966-4612. Fax: 919-966-6125. mnusbaum@med.unc.edu.

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