

An Intern Faces the Tragedy of a Maternal Death

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Received: July 30, 2015; **Published:** August 19, 2015

Abstract

Obstetrics is, for the most part, a happy specialty. A new intern faces an emotionally difficult situation as a healthy patient suddenly expires. Residency programs should be encouraged to address issues surrounding adverse patient outcomes within the formal didactic curriculum. Faculty mentorship may play a large role in preventing attrition and in helping residents through difficult experiences.

Keywords: Maternal; Labor; Death; Delivery; Gynecological

Perspective

As a new intern in a busy inner city hospital, my job when on call consisted of managing the labour floor, taking care of postpartum issues, and seeing patients on our gynaecology service as well as in the emergency room. This evening, like most calls, had been very busy.

A 38 year-old woman, Michelle, presented to Labour and Delivery at 39 weeks gestation for an induction of labour. Her attending physician had sent her because the baby had the umbilical cord wrapped around her neck. During her admission, I learned that my patient was essentially healthy, and that she had given birth to two wonderful sons, now aged two and four. This was expected to be her third vaginal delivery and her first daughter. Michelle and I had had so many similar experiences and interests that we bonded immediately. Michelle was raised in New York City, just a few blocks from where I grew up and, it turns out, had many friends in common. She and I had travelled extensively in Europe, had skied at the same resorts and enjoyed scuba diving in the Caribbean.

I examined Michelle and found that her cervix was only about 1 cm dilated, so I placed the induction medication as her doctor had ordered. The baby was estimated to be of average size and she looked healthy on the fetal monitor. I left the room, promising to come back later when I had some time to talk more, and headed down to see patients in the emergency department.

A few hours later, her private attending physician had arrived and the patient requested an epidural as her contractions had picked up. Labour had begun. I was relieved to be done with my ED consults, but this contentment was to be short lived. "Doctor, she's short of breath" said the experienced labour floor nurse who called from the delivery room.

I rushed to her bedside and was shocked to see Michelle so pale and having such a hard time breathing. Initially, I was hoping that this was just anxiety but soon discovered that my patient had suddenly become very sick. Her vital signs were abnormal, her heart rate was high, and I swiftly ordered many tests. The anaesthesiologist came running to the room, followed quickly by her private physician. Together we diagnosed a likely pulmonary embolus and began anticoagulation without delay.

"I feel slightly better with the oxygen" Michelle said, then rolled up her eyes and seized. The overhead monitors showed no blood pressure or pulse. Her heart had stopped beating. In seconds the anaesthesiologist intubated her. A minute or two later the entire code team rushed into the room and chest compressions were started but Michelle did not respond. During the resuscitation attempt, the fetal monitor showed that the baby was slowly dying from asphyxiation. I was surprised how calm and focused I was despite all the commotion,

all the people who were in the room and all the sounds of bells and alarms given off by the monitors. Despite being a newly minted doctor, I found myself become an integral member of the team fighting to save Michelle's life.

To facilitate resuscitation efforts, my attending and I performed an emergency classic c-section in the labour room. I was chilled by how little bleeding there was and by the dark, almost black, colour of the blood. The baby was handed off to paediatricians who tried to revive her, but all looked concerned by her appearance.

For the next two hours, the code team kept doing chest compressions and shocks, giving medications through the IV while ventilating the patient with a mask. The patient was transfused several units of blood and platelets, but she continued to bleed from every orifice. I kept praying and hoping that she would be okay, thinking also of her husband who was in the waiting room and her children at home.

"Stop compressions. Time of death 4:20!" the anaesthesiologist proclaimed after more than two hours of resuscitation. I felt the shock. For the first time, I became aware of my own rapid heartbeat, my dry mouth and the tingling in my hands. The fatigue, the grief, the fear (which I had managed to control during the emergency) overwhelmed me, and I started crying. I felt so bereft for this woman, for her now motherless kids and for her husband now sobbing in the waiting room across the hall. This family would be returning to a devastated life.

Later, when I returned to that labour room, it looked as if Michelle was sleeping peacefully. Somehow I just couldn't accept the obvious fact that my patient had died and I gently tried to wake her. Some of the nurses were seated around her, talking tearfully about what had just happened, trying to comfort one another. I started to cry again and left the room, trying to get my mind back together so that I could tend to my other patients.

For days, my mind kept going over and over what had happened, wondering if there was anything I could have done differently. At night the movie of these events kept coming back and I could see Michelle in my sleep. I thought about attending Michelle's funeral to seek some closure and to pay my respects, but felt that it might have been inappropriate and perhaps too self-serving. A week after this tragic loss, the Medical Examiner confirmed the suspected diagnosis of amniotic fluid embolus, an event so rare that many practitioners never encounter a single case during their entire careers. What had shocked me so much was the unexpectedness of this death. Obstetrics, for the most part, is a happy specialty where patients tend to be young, healthy women and where good outcomes are almost always expected. Just moments before her death, Michelle and I had been talking about her work as a teacher and how she met her husband. I needed more time to come to terms with this loss, but the busy overnight call schedule continued without letup.

It's been six months now since this experience unfolded. I chose to become an OB/GYN because I enjoy the combination of a surgical specialty with the provision of continuity of care and I appreciate being in a field where I can forge strong doctor-patient bonds. The range of opportunities to provide obstetrical, gynaecological, oncological and primary preventative care to women in ambulatory, hospital and operative settings fits uniquely well with my temperament and passion for helping other women. My family, friends and peers understand that Michelle's death profoundly affected my life and have all been very supportive. Despite the reassurances from colleagues that nothing else could have been done, and that I was not in any way responsible, I'm nevertheless uncertain now whether OB/GYN is the right field for me. I tend to second guess myself more, I dread the loss of another patient and professional satisfaction is now elusive and rare. Frequently, I still have recurrent intrusive thoughts about Michelle, her family and her baby who had been whisked away for treatment at a regional neonatal intensive care unit.

For the first time, I understand fellow residents who have questioned their choice of specialty and decided to exit the profession. The burnout and the attrition that I had heard about in medical school come to mind as I weigh the pros and cons of staying in OBGYN. Then there are the monumental financial and family sacrifices that this career has already extracted from my life, such as the missed weddings and, birthday parties, the time I couldn't make it to an aunt's funeral, and the time I had to find coverage when my sister required emergency surgery after a car accident. I believe that when we, as doctors, treat our patients as human beings, we deserve the same respect for ourselves and from each other. A nurturing residency program that would support residents' emotional struggles, such as with a patient's unexpected demise, would help create healthier and happier physicians and also lower our attrition rate. I know that I would

have welcomed any support or advice from faculty mentors, and, had there been any formal system in place, I would have benefited greatly from peer support. Personally, writing about this experience, putting words to paper, has already helped me come to terms with this tragic event. I'm sure that other doctors would benefit from small group narrative exchange sessions where important events could be written and discussed. Just as writing did for me, such sessions would help peers put in order their true thoughts, feelings and future intentions. Hopefully, for me, the seeds of a new resiliency and of a freshened professional identity can now emerge from the depth of this tragedy.

Volume 2 Issue 1 August 2015

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