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Focus on Professional Liability**Traumatic childbirth: Address the great emotional pain, too**

How do you treat incomplete grief and traumatic stress disorder amid the pressures of practice?

Mary Jo Foster, herself a physician, sat down to pen a letter to her former obstetrician. Words flowed easily because, for months, she had thought of little else besides the events of the previous year.

Her letter has been abbreviated, with names and dates altered.

Eric David Foster

Born: May 15, 2003, Died: May 18, 2003

Does that name or do those dates mean anything to you? They should, but I doubt that they do. I, on the other hand, have been haunted by painful and awful memories of those 4 days, as I will be every day for the rest of my life. I hope that you have the courage and integrity to read this letter completely, because this is the only chance I have to reach you.

Do you remember my first visit? I had the impression then that you listened and understood when I related my complicated obstetric history, but that was the first and last time I felt that way. You seemed to forget about the uterine septum until I called you at 25 weeks' gestation to report that I had gone into labor. My husband and I were so terrified, we left our sleeping 2-year-old son alone in the house to await the nanny in order to get to the hospital as soon as possible. Although we arrived there at 7 AM,

we had to wait 2 horrifying hours for you to show up. By then it was too late, and Eric was delivered prematurely with extensive brain damage from ischemia and hemorrhage. Distraught, my heart breaking and my brain dazed from shock, trauma, surgery, and lack of sleep, I then had to plead and fight at the ethics committee meeting for the discontinuation of life support so Eric's suffering could end.

A strongly worded letter if ever there was one; the patient's emotional pain comes through loud and clear. Bear in mind that the obstetrician's voice is silent; we do not hear his perspective.

That is intentional. The aim of this article is not to pass judgment or offer defense, but to draw attention to two specific consequences of a major traumatic experience—incomplete mourning and traumatic stress disorder.

In an earlier article, "The nightmare of litigation: A survivor's true story,"¹ I presented the case of an obstetrician who was sued for medical malpractice. The trauma of the experience led him to develop an acute stress disorder, which evolved into posttraumatic stress disorder (PTSD). In this article, the focus is on the patient, who also develops PTSD after an adverse outcome—specifically, premature delivery and neonatal death.

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For the past year I have wanted to ask you...

- Why did you make me feel invisible during my pregnancy, after I went to so much trouble to explain my special situation?
- Why didn't you seem to notice how terrified we were when I started bleeding? Instead, you took your time getting to the ER.
- Why didn't you come to talk to me later in the day after the cesarean section? When you spoke to my husband, you mentioned that you had removed the uterine septum so I could go on to have a normal full-term pregnancy. How could you begin to talk about another pregnancy while my son was in pain, bleeding into his brain? You wrote him off the minute you left the OR, just like you peeled off your gloves and dropped them into the trash.
- Why didn't you ask the chaplain to be at the ethics hearing as a support for us?
- At my postoperative checkup, why did you rip off the dressing and declare me "beautifully healed"? And why did you walk off before I could say anything?

A healthy mourning process comprises several stages, including denial, anger, sadness, and meaning-making, followed by acceptance and healing. This harsh letter is an indication that the patient is stuck in anger; healing is a long way off. Beneath the anger are other emotions, including sadness, shame, and guilt.

When the obstetrician ripped off the dressing and declared the patient healed, he was addressing the physical abdominal wound, but he completely overlooked the deeper, invisible, psychospiritual wounds arising from loss of a child—and from loss of safety, power, trust, faith, and meaning. The patient's feelings are striking in their potency, but the obstetrician remained unaware of them. At the time of her postoperative visit, these psychological wounds had not even begun to heal. The self that had been preparing to be a mother had not yet integrated all the loss-

es and realigned to the grim reality that she was now the parent of a dead baby.

Rather than further her healing, the obstetrician's words alienated her and added yet another layer of wounding.

Letter continued

That hospital was my personal place in hell from the moment I entered until the day I was discharged. You and your office staff seemed totally oblivious to this fact. Now a year has passed—a year of pure devastation—and I still have pain and sadness that cannot be understood by anyone who has not experienced the death of a child. And I have anger at the incompetent ER staff and at myself for being "a good patient" and ignoring my intuition.

I deserved a physician who can remember who I am and my relevant history—one who would come to see me immediately and reassure me that everything possible would be done for my baby and me. I deserved a physician who can acknowledge the awfulness of such a loss and offer sympathy and support. And to make matters worse, you immediately retreated behind the fear of a lawsuit.

Grief, interrupted: When the business-as-usual world interferes

An outpouring of grief in the face of loss is normal; it mobilizes energy and is an integral part of the healing process. Emotional healing may seem protracted when it is viewed in the context of chronological time, and pressing demands frequently interfere with the process. In this case, demands included the need to attend an ethics meeting, arrange a funeral, care for a 2-year-old son, host parents-in-law who had arrived from out of town, and, the following week, throw a birthday party for her son.

Disenfranchised grief: How wrong words, or none, can slow healing

This patient found little validation or support for her grief from those who were around her:

- Medical personnel acted defensively and insensitively.

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- Her in-laws kept busy, making idle chitchat while they fussed over the party and memorial arrangements.
- Her friends plied her with platitudes: “God needs an angel in heaven,” “God needed your son more than you do,” “We can’t know why God makes these decisions.”
- The priest performed the memorial service in ritualistic fashion. “He couldn’t even get Eric’s name right,” she lamented.
- Her return to work was marked by awkward cheeriness, “as if I had been on vacation.” Her boss’s comment? “Best hop right back in the saddle.”

All these people seemed invested in their own coping strategies. None provided comfort; empathy was absent. Any mourning that had to be done was done alone, behind closed doors and a fixed smile. Isolation, the hallmark of trauma, was pronounced. Only after she found a support group several months later was Dr. Foster able to openly mourn.

Three symptom clusters signal PTSD

Dr. Foster’s description of her postdelivery experience suggests to me that she sustained an acute stress disorder—a condition that involves feelings of intense fear, horror, disorientation, and helplessness in response to an unusually traumatic experience that threatens death or serious physical injury to self or others. In Dr. Foster’s case, the stress disorder progressed to PTSD—a pervasive chronic anxiety disorder characterized by three clusters of symptoms:

- **Recurrent, intrusive recollections of events; recurrent flashbacks and dreams.** “At night, after going to bed, I would see the fetal monitor showing my child’s heart rate running like a video stream in front of my eyes. This went on for months. It would take me 1 to 2 hours to force myself to fall asleep.”
- **Persistent avoidance of stimuli asso-**

ciated with the event; numbness and detachment. “I had feelings of numbness and unreality but couldn’t really understand or process them. Eating became difficult, and I was unable to experience any pleasure. Survivor’s guilt plagued me. Why am I alive? I asked myself. I had some 30 years, but my son didn’t even have a chance.”

- **Persistent symptoms of increased arousal; insomnia, hypervigilance, irritability, difficulty with concentration.** “I returned to work after a month but could not focus or concentrate, so I took 2 additional months off. Whenever I heard the obstetrician paged at the hospital, I had a physical reaction. My muscles clenched, my skin flushed, and my heart raced. Eventually, I stopped working at that hospital because I couldn’t stand being there.”

PTSD is not rare in civilian life or in medicine. Journal articles attest to its occurrence in association with major illness and injury,² spontaneous abortion,³ and premature and traumatic birth.⁴⁻⁸

In Dr. Foster’s case, PTSD went unrecognized and untreated.

How to avert, and alleviate, PTSD

As with any disaster, careful planning can mitigate consequences even though it cannot necessarily prevent PTSD. Prenatal visits offer a unique opportunity to build a trusting partnership with your patient and her partner. Skilled professional communication is essential. Anticipate common themes:

- **Fear of failure and shame** is an issue for many mothers-to-be. Here, your affirmations and good humor are helpful. Be very respectful of the patient’s interpersonal boundaries, both physical and emotional.
- **Disempowerment** is an inherent part of the patient experience; trauma aggravates this dynamic. Whenever feasible, shift some of your power to the patient by eliciting her wishes and

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An acute stress disorder involves feelings of intense fear, horror, disorientation, and helplessness in response to an unusually traumatic experience

offering her choices. Together, create a plan for delivery and postnatal care that reflects her desires. As you demonstrate competence and control, consciously deconstruct the image your patient may have of you as an infallible authority figure by selectively revealing a little of the personality behind the white coat.

- **Feelings of isolation** always occur with trauma. The bonds you cultivate with the patient during her pregnancy will alleviate this isolation, as will your message: *You are not alone in this experience; we will deal with this together.*

Other helpful practices

Allow the grieving couple space and privacy to ventilate and mourn any way they need to. This may include expressions of anger.

Listen silently and attentively even if you feel passive or uncomfortable doing so. Resist the urge to comfort the patient; even well-intentioned comforting can interrupt healing.

Validate the patient's trauma. Be careful to avoid making the suggestion that you understand. No one but the patient can understand—suffering is always unique and personal.

Express a genuine and carefully worded sense of regret for the patient's loss. Take care not to express personal negative feelings, such as those regarding a baby's deformity. Your words may become permanently imprinted.⁹

Present any information and recommendations the patient needs in writing because, when a person is in shock, she may be unable to recall verbal messages. Also give written recommendations to one of the patient's family members, if possible.

Avoid well-intentioned attempts to reassure a patient or to rationalize or offer premature hope. There is time for such things later.

Cultivate a referral network that includes social workers, chaplains, and psychotherapists trained to work with trauma

victims, and when they are necessary, involve them as early as possible. Also familiarize yourself with local support groups and short-term cognitive group-therapy programs for grieving parents.¹⁰

Frame the gesture carefully if you feel the need to refer the patient to a psychotherapist or psychiatrist. It is better to emphasize to the patient that she has sustained a major trauma than to suggest there is something wrong with her. The latter will only add to her sense of personal failure and may trigger resistance or anger.

Take care of yourself! You need your own practices and rituals to sustain you in the work you do. Create your own network of support. Concentrate on expanding your resilience and strive to be comfortable with your emotions. If symptoms of burnout appear, seek help quickly. ■

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Recommended reading

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Do not tell the patient that you understand her trauma. Suffering is always unique and personal.