When babies die: death and the education of obstetrical residents

SUSAN BRANDT GRAHAM, *Women's Medical Specialists, PC, 4640 Jefferson NE, Albuquerque, New Mexico 87109 USA*

SUMMARY *This paper, based on 4 years in a Department of Obstetrics and Gynecology in which the author was both a resident physician and anthropologist participant–observer, explores how obstetrical residents are taught to deal with the birth of anomalous and/or dead or dying babies. Not only is formal training lacking in this area, but residents may be strongly sanctioned for any emotional response in such situations. This paper argues that unless, and until, residents are taught to recognize and deal with, rather than repress, their responses, these physicians-in-training will not be equipped to help grieving parents deal with these situations.*

The death of a baby is one of the most difficult events with which obstetricians must deal. Such an event can produce feelings of inadequacy and guilt, as well as fear of a lawsuit. Many such deaths are unpreventable, and for some the cause is never determined. The ambiguity in such a situation can be as difficult to deal with as the reality of death. How are obstetricians-in-training taught to deal with their feelings and those of grieving parents?

Methods and materials

From June, 1985 until June, 1989 I was a resident in the Department of Obstetrics and Gynecology of a major Southwestern Medical Center. Before becoming a physician, however, I was a social anthropologist, a background which required me to be an observer as well as a participant. As Konner (1987, pp. xvi–xvii) has noted:

> I frequently found myself watching doctors instead of trying my damndest to become like them. Most of them didn't notice, but if they had they would have been annoyed, and I wouldn't have blamed them. Medical care and training are not spectator sports. They are hands-on matters of life and

> death. You are in it or you are out of it; there is no in-between. Or so the arguments go. Yet with all due respect, I *was* in and out of it at one and the same time. That is the paradox of participant observation...

Throughout medical training I could not help watching the functioning of that medical training, and its effects both on me and on others. This paper documents some of those effects. The program in which I was a resident stressed that residents should be sensitive to the needs of patients, and indeed hired a clinical psychologist, one of whose duties was 'sensitivity training' for residents. In spite of this, however, I will show that in actual day-to-day functioning on Labor and Delivery residents are systematiclly taught to deny their own feelings when dealing with the death of babies.

Case 1

During the 1985–86 academic year I observed an intern attempt for the first time to deal with a 'bad baby'. B. J. was a young single mother who had a routine ultrasound in her eighth month of pregnancy. The ultrasound showed severe hydrocephalus and anomalies incompatible with life. Amniocentesis revealed a chromosomally normal male; the cause of the anomalies could not be determined prior to the baby's birth. Because of the known lethal anomalies, however, the attending professors and upper level residents felt that the mother should not be exposed to the risk of Cesarean section. Therefore, after counselling the patient, the chief resident punctured the baby's head to drain out fluid which would otherwise make vaginal delivery impossible, and then induced labor.

Once the patient was in labor, management of the labor was handed over to the intern, who had never dealt with a dead or deformed baby. The intern was told nothing about what to do or what to expect, only that this was a grossly deformed infant whose skull bones would be collapsed upon themselves. The intern spent as much of the night as possible talking with the young mother, who had no friend or relative present for support. The patient requested a priest be present to baptize the baby when it was born; the intern was told the priests would not come to Labor and Delivery for a dead baby. After several phone calls the intern learned small bottles of holy water were kept in the delivery room, and a Catholic nurse was found who was willing to baptize the baby when it was born.

The patient progressed rapidly through the first stage of labor, but could or would not push effectively in the second stage of labor. The intern was aware of his own fear of dealing with a grossly deformed baby, and understood that the patient's inability to push could be caused by the same fear. The intern talked for a long time with the patient about her fears, who appeared relieved. The patient then began to push effectively and shortly thereafter delivered the infant.

The intern, understanding the patient's fear of looking at the baby, began to talk about all the things that were normal—the perfectly formed hands and feet, the well-developed body. The patient then asked about the head, and was told that the head indeed was quite deformed. The patient requested that she be given the baby to hold, but that the baby be wrapped up with nothing of the body exposed. After holding the baby thus wrapped, however, the patient slowly uncovered the feet, the legs, then the chest and arms. Eventually she slowly unwrapped the head. She was able to grieve appropriately, and did well postpartum.

Case 2

Three years later I observed the same physician—who was by that time a chief resident—deal with another anomalous baby. M. M. was a young patient who had recently been diagnosed—also by ultrasound—as carrying an anomalous infant, although again the exact anomalies were not known. Because of the anomalies, however, the attending professor along with the patient and her partner made the decision that no surgical intervention for fetal indications would be made in labor.

When the patient arrived in labor, the infant was found to be in breech presentation, which at the present time in this country usually calls for Cesarean section. Since the decision had already been made, however, that no surgical intervention was warranted, the chief resident felt that this was an ideal opportunity to teach the second-year resident how to deliver a breech baby. Rather than spending time talking with the patient, the chief resident spent pre-delivery time explaining breech delivery maneuvers to the junior resident.

The labor progressed rapidly, and as the delivery progressed the chief resident tried to demonstrate delivery of the legs—but the right leg would not deliver in the usual manner. The resident then again tried the maneuver on the left leg, but it would not deliver in the usual manner either. Trying not to show frustration or concern that things were not going as expected, the chief resident told the junior resident, "We'll just let the legs deliver on their own this time". When the legs did deliver, the reason for the difficulty became readily apparent—the legs were fused from the thighs to the feet, a condition dubbed 'Mermaid Syndrome'.

The remainder of the delivery went rapidly and without difficulty. At the conclusion of the delivery the chief resident stopped at the head of the bed and said to the patient, "The baby's legs are fused together—the pediatrician will talk to you in detail about that later. I'm sorry about your baby". The chief resident then took the junior resident and spent some time explaining how this delivery had differed from a 'normal' breech delivery, and how such a delivery would usually be done. The chief resident then went to bed. An observer was overheard to comment, "That resident has finally learned how to be a doctor rather than 'the patient's best friend'".

Discussion

What happened in three years of training to change this physician's response to and interaction with patients with anomalous babies? It should be stressed that this occurred in a department which pays something more than lip service to the importance of patient needs and caring responses to those needs. In spite of this, however, the resident discussed above had obviously learned during years of training different ways of interacting with patients in these situations. What had been taught—and why—in the training of the resident to produce a 'doctor' instead of a 'patient's best friend?'

Davis-Floyd (1987) has argued that obstetric training involves a process of detachment from a humanistic model and the acquisition of a technological model of life in general and of birth in particular. Michaelson (1988, p. 11) stresses a point made earlier by Brody & Thompson (1981, p. 977) that obstetricians are trained to deal with "worst case" outcomes. Such training, however, involves technological training, and when technological intervention cannot alter bad outcomes, the physician is left unprepared to deal with the human consequences.

It is often heard that physicians must become hardened to emotionally demanding

situations in order to protect themselves from overwhelming emotional drain. How are obstetricians trained not to show emotion, and does this training benefit either the patient or the obstetrician?

Training

In this Department of Obstetrics and Gynecology, training about anomalous and dying babies was limited to learning of different anomalies and what causes them, when causes were known. In this particular program there was no discussion whatsoever of the emotional impact of these upon either physicians or parents. In general terms in numerous meetings residents were urged to "be more sensitive" to the concerns of patients, but *never* were specific issues or feelings about bad obstetrical outcomes discussed.

Nurses were often encouraged to express their feelings about emotion-charged situations, and occasionally the department would organize group sessions with the departmental clinical psychologist to help nurses deal with various emotional issues. *Never* was anything similar planned for residents. By this fact alone, residents were given the unspoken but powerful message that nurses may have unresolved emotional issues and need to talk about them, but that *physicians* do not.

Residents are taught that they are to be in control of any situation at all times. They are told that "being in control" encourages confidence from patients. Appearing to be in control may become especially important in cases in which there is ambiguity and lack of knowledge. Many times the cause of an anomaly or of an infant death may not be known. Interacting emotionally with patients may expose the resident to thorough questioning in matters for which there may be no answer, and thus exposure to the fact that he is not in control.

Appearing to be in control may also be important in cases in which there may be some feelings of guilt. If a specific cause for a problem is known, there may be less guilt than in a problem in which the cause is not known and for which the resident may then believe he is responsible. For example, several residents have remarked that it is much easier to talk with the parents of a stillborn with trisomy 18 than with the parents of a stillborn baby with no apparent anomalies and whom the resident may have seen in clinic with a live fetus only two or three days before. In such a situation, avoiding interaction with the parents may also be a way of avoiding probing questions, questions which the resident may already be asking himself but for which he may not have answers.

What happens in this program if a resident does show emotion when interacting with patients? A faculty physician who observed a resident hold the hand of a patient and weep with her when she was told her term fetus had died, called the resident out of the room. The resident was sent home for the day (something unheard of in this program) and told to come back "when you can act more like a doctor". The faculty physician then proceeded to tell other residents that they "must be in control" and that the behavior he had witnessed was unprofessional. This lesson was not lost on the other residents, nor on the resident who was sent home, who vowed never again to show emotion to a patient.

In the past, a physician's lack of display of emotion was explained as part of a "hardening" process in which the physician learned to protect himself from hurt. I am not convinced that this is the case. In the obstetrical training program described here, the majority of faculty state that residents should show concern and compassion for

patients with dead or anomalous babies. In spite of this, however, the residents are systematically taught to suppress their own feelings and along with them, any display of emotion. Residents are provided no outlet for talking about their feelings or even admitting that they have them—and residents who do show emotion are publicly sanctioned. What is the function of such training, and has it become dysfunctional?

The sharing of emotions breaks down social barriers and creates social equality. Therefore, the sharing of emotions with another group (for example, patients) may be defined as inappropriate by those who feel that they belong to a higher social group (for example, physicians). In the past this may have been functional for the physician in order to minimize feelings of guilt and ambiguity while giving the appearance of being in control. In the same sense it may even have been somewhat functional for patients, if indeed they ever had the belief that somehow 'the doctor would just take care of everything'.

But if such a feeling ever existed, it is an anachronism today, as is the behavior which follows from it. We are in an era of consumerism in medicine, one in which the failure to show emotion may be seen by the patient as arrogance or, at best, lack of concern and compassion on the part of the physician. The physician who has been taught—and learned well—to suppress feelings may be completely unable to help parents deal with their feelings of loss, guilt, anger, and depression, although it may be very important for patients to work through these before they proceed with another pregnancy.

Recommendations

I believe that obstetrical training programs must do more than pay lip service to the desirability of producing sensitive and caring physicians. I would recommend the following as a minimum:

1. Open discussion within the training program of the impact of death and anomalies on patients *and* the physicians caring for them;
2. Support, either in groups or through personal counselling, of residents learning to deal with anomalous and dead babies and the feelings of conflict, guilt, and inadequacy these can produce;
3. Positive, rather than negative, sanctions for residents who are able to express concern and compassion for and to their patients.

I believe that only then will these obstetricians-in-training become obstetricians in practice who are capable of helping their patients deal successfully with one of life's great tragedies—the loss of a child.

REFERENCES

BRODY, H. & THOMPSON, J.R. (1981) The maximum strategy in modern obstetrics, *The Journal of Family Practice*, 12, p. 977.

DAVIS-FLOYD, R.E. (1987) Obstetric training as a rite of passage, *Medical Anthropology Quarterly*, 1, pp. 288–318.

KONNER, M.E. (1987) *Becoming A Doctor: a journey of initiation in Medical School* (New York, Elisabeth Sifton Books).

MICHAELSON, K.L. (1988) Childbirth in America: a brief history and contemporary issues, in: MICHAELSON, K.L. (Ed.) *Childbirth in America: Anthropological Perspectives* (South Hadley, MA, Bergin & Garvey).