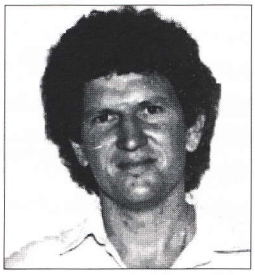
Obstetric errors – two patients and a doctor

Dr ID Couper
BA, MBBCh, MFamMed

S Afr Fam Pract
1996;17:61-66

KEYWORDS
Physicians, family;
Mistakes;
Attitudes of health personnel;
Physician – patient relations.



Curriculum Vitae

Ian was born and schooled in Port Elizabeth. He graduated from the University of the Witwatersrand with a BA (Psychology) in 1983 and a MBBCh in 1987. He worked at Livingstone and Dora Nginza Hospitals in Port Elizabeth before going to work as a volunteer with the Anglican Church in Paraguay. In January 1991 Ian commenced work at Manguzi Hospital, where he has been acting Medical Superintendent since August 1993. He was submitted to alternative service as a conscientious objector, completed in September 1993. He completed his M Fam Med through Medunsa in 1995. He is married to Jacqui, an occupational therapist, and they have two sons.

Department of Health
Manguzi Hospital
Private Bag X301
KwaNgwanase
3973

Summary

I present my encounter with two patients whom I saw in the Manguzi Hospital Labour Ward during nights on call. In both instances I made similar mistakes which led to the babies dying. This realisation had a dramatic impact on me. I discuss the issue of doctors' mistakes and indicate some of what I have learnt through my emotional reactions and other people's responses.

THE ENCOUNTERS

The context

Manguzi Hospital is a 280 bed rural hospital in northern KwaZulu-Natal. Like most similar hospitals, there are no specialists and medical officers are involved in the full spectrum of clinical activities – obstetrics, paediatrics, medicine, surgery, etc. The doctor on call covers all wards, with one colleague (who may be less experienced) as back-up. The majority of patients are simple rural people who have limited resources and education.

First patient

I was called to see LM, a single 20 year old primigravid lady, late one night after she had spent a day in labour and had got stuck at 6cm cervical dilation. Having assessed failure to progress due to ineffective contractions, I prescribed syntocinon augmentation. Five hours later, the cervix was 9cm dilated but the foetal heart was averaging around 100 bpm. I stopped the syntocinon infusion.
After two hours, the patient had not delivered despite being fully dilated for

an hour, and was totally exhausted, with resulting incoordinate contractions. I restarted the syntocinon infusion. An hour later the baby had not moved. I assessed her as having CPD (finally!) and took her for a Caesar (finally!). At operation, the head was impacted in the pelvis and delivery was extremely difficult, requiring manual disimpaction per vaginam. The baby was very flat and required extensive resuscitation. He picked up initially, but afterwards became jittery with thumbing and scissoring. Lumbar puncture showed a xanthochromic CSF. Two days later he suddenly stopped breathing. After prolonged resuscitation, largely driven by a refusal on my part to let this baby die, I declared the child dead. With the usual reluctance I informed the mother, stating the cause to be birth trauma.

Second patient

About a week after my encounter with LM, I was called to see TM, a single 19-year old primigravid lady, because her baby's heart rate was dropping during contractions. She had been in labour for a few hours. The cervix was 6cm dilated but the head had not come down and the liquor was thinly stained with meconium. I did not intervene.

An hour later she seemed to be progressing well and I expected delivery fairly soon. Having attended to patients in other wards, I returned after nearly two hours to find TM fully dilated. There was thick meconium, so after another half an hour, I tried a vacuum extraction. After three attempts failed to move the head, I did an emergency Caesarian section and extracted a flat baby covered in thick meconium. Extensive resuscitation was done, while I completed the Caesar uneventfully (on the surface). I informed the mother that the baby was having problems but I was too tired and depressed to be very communicative.

The baby was treated for meconium aspiration syndrome. The next day he vomited coffee ground material and became jittery; subsequently he stopped breathing. I went through all the motions of resuscitation to no avail and certified him dead.

At this point I wanted to run away, to hide, to weep, to give up medicine – anything but go and tell that mother that her baby was dead. I went ahead and did it nonetheless. I do not remember what I said to her – I was in a daze – but basically went through the same process again as I went through with the first, without telling her of any mistake I had made or my feelings that I was a murderer. I never shared my agony with my patient, or asked for her forgiveness: "Somehow, I felt, it was my responsibility to deal with my guilt alone"[1].

Should I have intervened sooner?

My immediate response

I went into a state of recoil, of horror and depression. I did not want to go back to work the next day and had to force myself to go through the motions. In this state I wrote down some of my thoughts at that time on a scrap of paper, which included the following:

Am I competent? How will I know whether or not I am competent? Who will tell me when I am no longer competent? How do I avoid making the same mistake over again?

Mistakes are inevitable in the practice of medicine.

I am going through a grieving process, following classic stages: denial – there was no mistake, my decisions were reasonable, anyone else would have done the same; anger – mainly directed at the nursing staff (they should have done things differently, called me sooner), but also at my colleagues (irrational); bargaining – while the baby lived I was making deals in my mind; depression – still present; acceptance – what is this?

Obstetric errors

Who can I speak to about my doubts? Who will be honest with me about myself?

Is the real problem concern for my patient and her child or is it my pride? Do I want punishment? sympathy? a fight? justification?

Mistakes

"Our profession is difficult enough without our having to wear the yoke of perfection."[1]

In this article, I will not attempt to discuss the actual mistakes made. Suffice it to say that in both instances I should have intervened much sooner. I both did not take the partograph seriously enough and forgot the principle that any labour in a primipara is a trial of labour.

Firstly, a few comments on mistakes in general. A mistake can be defined as an act or omission for which the doctor felt responsible that had serious or potentially serious consequences for the patient and that would have been judged wrong by knowledgeable peers at the time it occurred[2]. Mistakes are inevitable in the practice of medicine because of the complexity of medical knowledge, the uncertainty of clinical predictions, time pressures, and the need to make decisions despite limited or uncertain knowledge.

It is commonly assumed that errors are a result of taking shortcuts, inattention to detail, or lack of knowledge of the explicit rules, but evidence casts doubt on this[3]. Mistakes can come about at a number of levels: an inaccurate or incomplete data base (history and physical examination primarily); an error in data analysis (eg over-interpretation of abnormal laboratory data); underestimation of the risks of evaluation or treatment (as compared with the risks of no evaluation or treatment); and unwillingness to risk a bad outcome (the desire for a perfect outcome in every case despite the cost to those who would not have a bad outcome if left alone[4]).

It is one thing to acknowledge that mistakes occur; it is quite another thing to analyse them rationally. "Everyone, of course, makes mistakes, and no one enjoys the consequences. But the potential consequences of our medical mistakes are so overwhelming that it is almost impossible for practicing physicians to deal with their errors in a psychologically healthy fashion."[1]

Almost impossible to deal with your errors in a psychologically healthy way.

I now wish to try to look a bit further at my own questions – the things I asked myself in the days following the realisation that I had made the same mistake twice.

1. *How do I know whether or not I am competent?*

Competence is a vitally important issue. Studies have found that between 8-15% of family practitioners and about 2% of specialists have serious deficiencies in competence[5]. The prevalence obviously depends on how incompetence is measured but no one disputes the existence of a problem.

Incompetence often persists among hospital doctors merely because the medical staff are old friends not used to commenting on each other's performance. A patient dies and the doctor is left wondering whether the care provided was adequate; there is no way to be certain and colleagues are reluctant to express an opinion[1].

The possibility of a serious mistake exists with every patient one sees.

The problem in South Africa is that incompetence is only discovered through direct complaints of the public. Peer review and recertification are still only topics of discussion (yet already feared by many!) A system of audit may help doctors who are sick or fall below standards. If anything has convinced me of the need for and

importance of peer review, it is this experience.

I still live with the same questions; in a way that encourages me: if I did not have this concern about my own competence I would be more likely to be or become incompetent. It is this which will drive me to read journals, to attend conferences, to discuss with colleagues, to accept peer review. At the same time, I have to face that doubt will always be with me. I can harness this to prevent arrogance on my part (which I am certainly guilty of at times) and to assist others; I hope it makes me a better teacher.

I have to accept that I will never be omnicompetent. The issue is honesty and acknowledgement of errors, to myself, to my God and to my patients – if I am not doing that, then I am a danger to my patients.

2. *How do I avoid making the same mistake over again?*

The crux of the matter is that the possibility of a serious mistake exists with every patient one sees. It is hard to live with that knowledge, but even harder after a serious mistake has been made to continue in daily practice and expose ourselves again[1].

A lot of this has to do with guilt; how do we as healers cope with guilt? Doctors use various methods of coping with guilt. We sometimes try to transfer blame to others, or ensure others share the responsibility; we may conceal or change certain facts, or we may seek to shrug it off ("It can happen to anyone"); we may seal it off in our souls, so that we are aloof and apparently unemotional. It is as if we are stuck in one of the early stages of grieving. Sometimes we deal with guilt by becoming experts in limited areas where we cannot be challenged, or we will even seek to escape by going into non-clinical fields. The only real answer for guilt is spiritual confession (acceptance of the blame), restitution and absolution, yet there is no place for this in the structure of modern medicine. To say "This is the mistake I made – I'm sorry" does not fit into the doctor-patient relationship[1], or even into the doctor-doctor relationship. Hilfiker[1] notes that because of this it is little wonder that physicians are accused of having a God complex; little wonder that we are defensive about our judgements; little wonder that we blame the patient or the previous physician when things go wrong, that we yell at the nurses for their mistakes, that we have such high rates of alcoholism, drug addiction, and suicide.

I do make mistakes, but do not consistently make mistakes.

I have to accept that I had been complacent and perhaps overconfident, and this is something I need to guard against. Most people, including doctors themselves, expect doctors, subconsciously at least, to be perfect, and I am included in that.

I hope this article will ensure that I do not make the *same* mistake again, but I will certainly make *other* mistakes.

3. *I have been going through a grieving process: denial, anger, bargaining, depression, acceptance.*

Approaching three years later I have moved past the depression stage into a measure of acceptance, though that acceptance has been shaken a little by reopening the wounds as I have written this article. I believe that acceptance is a state of recognising that I am fallible, that I did make mistakes but that I do not consistently make mistakes, and that the possibility of making another mistake is always there, a reason both for caution and for humility. The emotions expressed are normal and typical. Emotions experienced by house officers after a mistake have been listed as remorse (81%), anger (79%), guilt (72%), and inadequacy (60%). A few reported a persistently negative psychological impact[2]. In the

Share them rather than bury them.

future I need to learn to express these emotions, in healthy ways, and share them, rather than burying them.

4. Who can I speak to about my feelings and doubts?

Obviously I did speak to my wife, but in a sense she is too close to me, too accepting of me, too comforting. When I did try to share some of my feelings with colleagues at work, they brushed me aside, or said these things happen to everyone and I must not worry about it. In a study of house officers, 48% felt that when they discussed their mistakes the tough issues were not addressed, 27% felt the institution inhibited discussion of the mistakes and 20% felt the administration was judgmental[2].

I do not blame my colleagues in this. I think I may have reacted the same way towards myself after the first patient encounter – perhaps it required a second one in rapid succession to bring the issues into focus. The medical profession is not geared to expressing one's mistakes or facing one's doubts. Furthermore, I am sure there was the subconscious fear in others of what dealing truthfully with me might have brought up in themselves, the feelings and doubts that have been buried during the years of training and practice, because that is the mould we are put into.

One person does stand out, an experienced rural practitioner who had also completed a family medicine course. When I shared my experiences briefly with him, he acknowledged how he had made similar mistakes, had been through a similar process and had had similar questions. The recognition that my feelings were real and the empathy of someone who could identify with those feelings was a great encouragement.

If a doctor has made a mistake his or her feelings of guilt may be overwhelming and shame makes it difficult to admit errors. There should be a suitable framework to admit these feelings and understand what is happening[2]. We are unprepared. We need to help each other to confront the emotional consequences of mistakes. Medical school teaches precision; mistakes are not mentioned. This is something that needs to be addressed by medical schools and especially in postgraduate training programmes; registrars, for example, could be encouraged to deal with their errors through the example of their teachers facing up to their own blunders (as opposed to the witch-hunts sometimes observed in academic perinatal mortality meetings.)

Someone who recognised my feelings were real, was a great encouragement.

5. Is the real problem concern for my patient and her child or is it my pride?

How do I respond to this? Of course I was devastated because of the suffering I had caused. If it were anything else but human life involved I would not have reacted the same way. BUT ... pride was also involved. To make the same mistake twice is not only inexcusable, it is humiliating! I am sure a lot of these questions arose from that fact – my erstwhile pride was grovelling around on the ground, railing hysterically at the world because of the blow (unfortunately not mortal) it had received. Even now, that same pride sits on my shoulder doing its best to stop me from transcribing the damaging facts and responses!

Medical school teaches precision; mistakes are not mentioned.

6. Do I want punishment? sympathy? a fight? justification?

I think at different stages I was looking for all of these and they are simply indicative of the real emotions I was experiencing. As I write this article, I have to ask if I am still looking for any of these, and in response my answer is similar: at different stages in the process of reliving those events and writing this article, I have wished for each of these from those who may read

it, just as I have felt towards myself: judgement, pity, anger, palliation, etc. I think, above all at that time, I wanted empathy, a recognition that my feelings were real and appropriate. At this time my purpose in setting this down has been for my own growth and learning and to help others to face up to and deal with their own mistakes, or at least their vulnerability to error.

Perhaps more such studies will appear in this journal as we learn to reflect on our practice, including our errors, in a healthy and honest way.

Conclusion

Will I make the same mistake again? I cannot answer that. I hope I have learn't enough to avoid that, yet I have also been reminded of my vulnerability and the danger of overconfidence, so though I could write volumes on what I might do, I give no categorical response.

I do hope I can be of help to colleagues going through similar experiences and remain challenging to myself and to my peers to face up to mistakes in honesty.

Since writing this I have had a very positive though stressful experience of confessing an error to a patient who was also a friend and colleague, which has thus cemented some of my learning into practice.

I wish to express my appreciation to Doctors Jon Larsen, Jannie Hugo, Steve Reid and Chris Ellis for their feedback and encouragement.

References:

1. Hilfiker D. Facing our mistakes. New Eng J Med 1984;310(2):118-22.
2. Wu AW, Folkman S, McPhee SJ, LoB. Do house officers learn from their mistakes? JAMA 1991;265(16):2089-94.
3. Schmidt HG, Norman GR, Boshuizen HPA. A cognitive perspective on medical expertise: Theory and implications. Acad Med 1990;65(10)611-21.
4. Mold JW, Stein HF. The cascade effect in the clinical care of patients. New Eng J Med 1986;314(8):512-4.
5. Smith R. Dealing with sickness and incompetence: success and failure. Br Med J 1989;298:1695-8.

We need publications on our errors to learn from one another in an honest, healthy way.

Comment by Jacques Kriel

Dean: Faculty of Medicine, Medunsa

This article is important because it deals with an area of medical practice (medical errors) that is not given sufficient attention in under- and postgraduate research and education and in professional organisations. It focusses mainly on the emotional problem faced by the health professional on realising that she has made a serious diagnostic or therapeutic mistake, and explores the responsibility of the individual professional and his or her colleagues. But there is also a growing body of literature examining why mistakes are made.

The common assumption is that mistakes are due simply to a lack of the required knowledge or skills base or are otherwise due to negligence. The response by the profession is to organise refresher courses and to increase the number of specialities and sub specialities. The more you know, the argument goes, the less likely you are to make a mistake.

Although this is valid up to a point, cognitive science research has, however, shown that the diagnostic process is not simply a question of the direct application of knowledge 'in memory' to the problem 'at hand'. In his two books The Reflective Practitioner and Educating the Reflective Practitioner, Schon has for example argued that the professional has to construct the problem. Text books present our professional conceptual schemes ('scientific knowledge') as a neatly organised package, but the problem as it presents to us in the real world is more like a messy swamp from which we have to construct the vague outlines of a problem. The messiness of the real world is not only due to messy factors 'in the patient' or 'in the system', but also 'in the doctor and 'in scientific conceptional schemes'!

Medical educators and the profession seem to assume that mistakes are the exception, but if we listen to the seemingly growing dissatisfaction of patients, then it is clear that we can make mistakes even if the diagnosis and the therapy are technically correct! This is because we have largely ignored the most obvious of all facts, namely that both the doctor and the patient are human beings, not machines, and that the doctor-patient interaction is one of communication between two (or more) life-worlds.

Family practitioners, I believe, have a vital responsibility in exploring the whole field of medical errors and of educating the profession in this regard. It is becoming urgent as the profession in this country moves towards peer review and attempting to motivate young doctors to move to rural hospitals.