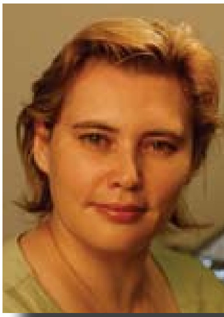
Three deaths in six months

One registrar's experience



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It stays with you…I was a fourth year registrar working at a large regional hospital. I had successfully passed my membership exam in the first half of the year and I was feeling that I was finally coming to grips with our demanding specialty.

That morning, I was in antenatal clinic. The first patient of the session was aged in her late twenties at 26 weeks gestation in her second pregnancy. She just 'didn't feel right' and had come to the clinic not complaining of anything specific. Her mother and existing child had come along as well.

The room was set up with the consultation area separate to the examination area. I took her through to the examination area and left her family in the consultation room.

Her blood pressure was 180/110. Urinalysis that had already been done by the midwife showed 4+ proteinuria. So my provisional diagnosis was pre-eclampsia and I did a full exam including listening to her chest, as well as checking reflexes (which were normal) and clonus (which was absent). The fetal heart was 140 and fundal height was appropriate. I sat her up and rechecked her blood pressure which was much the same. My mind was busily turning over how to form the phrases to let her know how serious things were. I had just started to say, 'I think you have pre-eclampsia, which is a dangerously high blood pressure coupled with…' and in the middle of the sentence she suddenly clutched at an area between her shoulder blades. Her eyes turned up, she went pale and then she started fitting. I called an arrest, enlisting the help of the family in the next room, as there was no arrest bell to hand (this has subsequently been rectified) and all the doors were shut.

The team arrived with commendable promptness, by which time (only a few minutes) she was pale and pulseless. All attempts at resuscitation of the woman were ineffectual. A discussion was had about doing a caesarean section in the room whilst we were trying to resuscitate the mother. My consultant made the call that at 26 weeks, caesarean section in this setting was not indicated.

At autopsy she was found to have had a thoracic aortic aneurysm that had burst secondary to the high blood pressures. These were indeed thought to be pre-eclamptic. It was thought that the weakness in the aortic wall was secondary to malnutrition from anorexia nervosa that she had suffered from earlier in her life. It also came to light that there had been alleged sexual abuse from a family member which had triggered the eating disorder. Ironically, it was that same family member that was subsequently most confrontational about her death and most vocal about perceived lack of care.

I remember being led to a side room after the resuscitation by one of my consultants. Everything looked very sharp and clear, like there were fluoroscent lights everywhere. I remember that I kept saying, 'She just died, she just died, she was right in front of me and she just died.'

'In sharing this story, I hope that we are all reminded of our duty of care to our colleagues, without which I may well have succumbed myself.'

I was in this regional centre by myself at the time. I was there for my rural term of 12 months and my husband had stayed at our home in the capital. So when I was sent home early, there was no one there. I don't remember much of the next few days actually, but I think that I was back at work the next day.

I'd like to also relate some extra background. The week before I started work at this regional centre and six weeks before the written membership examination, I was called to give evidence at an inquest on a maternal death that I had been involved with two years previously. This was a non-English speaking multiparous women who had come in at 7:45 am as I was coming off night shift as a (just) second year registrar. A senior midwife had taken her into a birth suite to do a vaginal examination, as she was screaming and appeared to be in strong labour. That was the extent of my involvement with her care prior to the arrest bell ringing at about 8:10 am. At this time we had both the night and day obstetric team, including the consultant of the day in the handover room. We all rushed to attend the patient who was pale and pulseless. Resucitation commenced and a caesarean section was performed in the room during the resuscitation. The baby was born dead and the mother also succumbed. Autopsy was inconclusive, hence the inquest. Nothing more was really learned at the inquest and this death is still unexplained.

So a second death coming on top of this experience (even though it had occurred some two years ago) was very confronting. I went over the events in my mind endlessly, trying to see if there was something extra that I should or could have done. All of my colleagues were amazingly supportive and after the initial few days, professional life started to get back into its groove.

I was then listed about a month later to go to theatre for a hysterectomy, under the supervision of the director of the unit. This was always a great opportunity to operate with a senior surgeon,

so I was very much looking forward to this. The patient in question was perimenopausal and had come in earlier that week bleeding heavily. She had become anaemic, with a haemoglobin around the 7g/L level. She was transfused and medical management instigated with moderate success. Hysteroscopy dilation and curettage (D&C) had been performed earlier to see if there was any intrauterine pathology and if a mirena would be suitable (it wasn't).

A hysterectomy seemed to be the only option as she was continuing to bleed. Accordingly, she was prepared for theatre two days later, with myself and the Director. We were scrubbing up as anaesthesia was being induced, when the arrest bell went off. Again, every effort was made to resuscitate her, but to no avail.

I have a very hazy recollection of events after that. I remember saying over and over again, 'They all die, they've all died'. I remember being held tightly by the Director. Again, I don't remember being sent home, I don't remember much of what I did. I do remember going to a counselling session with a psychologist under sufferance – this had been strongly recommended by the Director, whose opinion I respected. Therefore I had gone, but not I think with an open mind.

Life went on. I went back to work and my husband moved to be with me for the second six months of the year. The second autopsy determined that it was a drug reaction that caused the death and that nothing could have been done. Again, everyone was incredibly supportive and I finished my year before going overseas to do my final two years.

Given the quoted rate of maternal mortality of 8/100,000, 'unlucky' for me didn't begin to cover how I felt. Still being a relatively junior member of the team, as well as being isolated from my family, combined to make the whole experience one that still haunts me. I can feel myself becoming upset as I'm writing this article, years later.

Death is a part of living. In our work with the biological processes of birth and reproduction, it is inevitable that some of our patients will succumb. It is also inevitable that there will be nothing that we can do as doctors to prevent that happening. Doctors working in other specialties with unwell, older patients face these challenges much more frequently. But we are in the enviable specialty where the majority of our obstetric patients are young and healthy. There is also the emotional impact of losing a mother and a child, as opposed to an elderly person with cancer for example. It just shouldn't happen and when it does, it's twice as hard to accept.

As doctors I think we have to remember to be gentle with ourselves and allow ourselves to become upset over loss – we are human as well as professionals. It's alright to grieve over the loss of a patient. I think that it's also very important not to let these feelings take over and to seek professional help to give you the tools to do that. Ultimately however, it's a solitary journey that you make and no one however close to you can 'walk a mile in your shoes' for you.

I was asked by a colleague to write this article, as she was aware of the circumstances that I had found myself in. In sharing this story, I hope that we are all reminded of our duty of care to our colleagues, without which I may well have succumbed myself.

Acknowledgements

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