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Review Article

Second Victims in Maternity Care – The Hidden Fallout of Parental Birth Plans

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Abstract

In an era in which we strive for patient-centred care and shared-decision making, it is important to still consider provider perceptions and attitudes toward birth plans. In this case report, we describe maternity care providers as the Second Victim when non-standard birth plans are enacted and discuss the emotional and psychological turmoil of forced professional passivity. We present the fallout of contemporary, patient-empowered decision-making when a mother's right to refuse care recommendations is inviolate. Care providers have become unable to do what they know they should; the things they are trained for and know are expected of them by peers and principles of best practice, and yet, by default, must still participate, and share responsibility for whatever outcome ensues.

Keywords: Autonomy; Birth plan; Rights; Consent; Childbirth; Labour; Risk; Victims

Introduction

The term "Second Victim" was introduced in the 1980s by Dr Albert Wu to describe the aftermath of stress and grief that may be experienced by Healthcare workers following errors in medical treatment [1]. For some, this was contentious, arguing that it took focus away from the actual victim, the patient for whom harm occurred. Sympathies, however, have broadened, and there has since garnered genuine compassion for how practitioners cope following unintended care outcomes. It reminds us that these are fundamentally good people, trained professionals who mean no harm and yet have found themselves in situations where an error has occurred, often because of things beyond their control for which they were still held accountable.

This report expands the definition to include maternity care workers who experience grief not because of error but because of the inability to stop error when they are not permitted to do the things they know they should, the things they are trained for and are expected of them by peers and yet, by default, must still participate in non-standard pathways of care. We describe the testimony of such workers to highlight the emotional and psychological turmoil of forced professional passivity when contemporary, patient-empowered decision-making gives the right to refuse best practice. In many ways, the quandary is not novel. The refusal of Jehovah's witnesses to receive whole blood products, and the informed decision of patients who refuse recommended treatment plans, have vexed medical care for many long years. Such discord is now sounding in the birthing suits of many maternity care units, where women who choose to birth in hospitals are taking charge of their own care.

Childbirth has become, for many, a designed experience of parental choice. The right to plan and organize one's birth has become an unquestioned right for whomever it belongs. It is owned, like a commodity, and the outcomes are assumed safe with all the same guarantees expected of any commercial transaction. Government legislation, professional colleges, and, ever more loudly, social media platforms have championed the conviction that this is so. They advocate a birth plan, a written document that articulates the nature of care and intervention permitted during their stay [2,3]. It is a form of consent no less powerful or binding than the permission one would seek for a surgical procedure. It details what can be done and what can't. It says who can and can't be present and may even exclude any medical presence from the delivery environment entirely.

The definition of a birth plan has been described by many. Epstein et al. proposed it to be a process that is informed by the needs and perspectives of both the patient and the physician for participatory decision making [2,3]. Afshar, et al stated that birth cannot be planned, but preferences can be shared, and the provider must ensure that all parties are adaptive and flexible given the unpredictable nature of childbirth [4]. Our purpose is not about saying yes or no, to a person's right to choose or to uphold their autonomy to decide what may or may not happen during their birth experience. It's about understanding how significant the fallout can be when the risks caused by doing so affect not only the woman but the baby she carries within her, unborn. It's about hearing how caregivers respond to the dilemma of being forbidden to do what they're trained for and are left unable to make decisions or take actions that their profession normally expects of them. It describes the cost of disapprobation, of feeling disempowered as near misses flaunt risk with harrowing margin, or harms usually avoided wreak an inevitable toll [5]. We ask what happens when the right to demand too little becomes an expectation that asks too much.

We present a case report of a difficult birth in which the normal conduct of care was obstructed. We hear the thoughts that remained with the care givers after the baby was born and taken away for further care; when the woman recovered, and the room was cleaned and the bed remade; we see how it felt to pick up the pieces of something they witnessed but could not change. We ask ourselves, how do we take care of our own? How do we get through this? How do we help make

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a difference for others when we know it will surely happen again?.

Case Presentation

We present with permission the case report of a 30-year-old woman, G2P1, who arrived at our birthing suite at 41 weeks gestation in early labour. The patient was known to us, having engaged with antenatal services early in her pregnancy. She had diet-controlled gestational diabetes and had presented twice, at 29 weeks and then again at 32 weeks, with unexplained antepartum haemorrhage (APH). No cause for the bleeding was found. Her first pregnancy was also complicated by diabetes, and she was induced at 40 weeks. Unfortunately, this did not lead to a natural delivery. She did not progress to second stage, and an emergency caesarean section was required at 8 cm. In her current pregnancy, she expressed her desire to deliver vaginally and was counseled appropriately. She engaged a doula to comfort and advocate for her during birth and presented a written birth plan to express her wishes for delivery at the time of labour.

On the morning of arrival, she presented with her doula and husband, experiencing contractions every 2-3 minutes. Her waters had broken at home 3 hours earlier and were said to be clear though there may have been a tinge of blood staining. Upon settling onto the birth suite, she declined any form of examination or to be seen actively by the medical team. She refused CTG monitoring and declined intravenous cannulation. She gave the attending midwife a copy of her birth plan and emphasized that she would refuse to accept anything that was not included in her wishes. Her plan included links to the Australian College of Obstetrics (RANZCOG) website, which supported her autonomy. She thus affirmed powerfully that it was her right to have her birth in any way she desired.

The hospital midwife was concerned and escalated to the clinician on-call and the midwife in charge of the maternity unit. The birth plan was reviewed, and permission to discuss specific concerns was sought from the patient. The discussion was difficult. The labour was becoming more intense, and the woman's intention was more inwardly focussed. Much of her communication was mediated by the attending doula. However, the maternity team could respectfully and objectively voice their concerns and recommendations for best practice. These were heard, some were accepted, and others discounted. The midwife was permitted to listen intermittently to the baby's heart using a handheld doppler, but examinations, including vaginal assessment for progress, were not.

Over the next 20 minutes, the midwife noted a rise in fetal baseline heart rate from 120 bpm to over 170. No decelerations were heard, but the efficacy of auscultation was restricted by maternal agitation. Labour continued over the next 3 hours, during which the patient found comfortable positions while her doula stayed close, encouraging her with words of whispered support and close physical embrace. Her partner was in the room, standing or sitting close behind, present but somewhat separate from both.

She began spontaneously pushing whilst standing in the bathroom. She was birthed soon after, with the midwife attending and the doula close by. The obstetric teams were not allowed in the room. There was some delay after the head crowned onto the perineum; the midwife asked the mother to push actively because the fetal heart rate was difficult to hear. The baby was born pale and floppy 3 minutes later without crying or spontaneous movement. The midwife activated an emergency code, and the paediatric team waiting outside entered immediately. As the midwife attempted to cut the cord and bring the baby to them, the doula objected, saying the woman wanted to delay separation so she could keep the baby close for skin-to-skin contact. The midwife over-ruled and took the baby for active resuscitation. Apgar's were one at one minute and five at five minutes. The baby was transferred to Special Care Nursery for respiratory support (CPAP) and IV antibiotics and was discharged to the ward four days later. The mother had a small perineal tear which was left unsutured. She was moved to the postnatal ward soon after delivery and went home with her baby on day five. She was seen each day by the medical team; she was happy and wrote a letter of thank you to the hospital, expressing how happy she felt about her birth experience.

Discussion

Birth Is a Natural Event – So It Should Work Naturally

A woman's experience during labour may begin with the excitement of knowing things are as they should be. Her contractions or surges develop gently, progressively strengthening as focus on her body deepens, breathing everything in, one moment at a time. Her world becomes narrow; she is less aware of the things and people around her, moving into a 'zone' where the powers within her brindle and the innate, unharried strength of human 'being' move her and her baby irresistibly towards birth [6,7].

"In the most intense hours of labour, I became mindless, floating in boundless space between contractions. All thoughts receded. My mind plummeted into an immense silence bathed in love and well-being. I felt a oneness with all mothers who had ever birthed" [8].

This is how things are. This is how they should be and how they would be if we simply allowed them to do so [9].

But What Happens When Things Don't Work Out? When the Things That Happened aren't Supposed To, Or the Things That Were Meant To, Didn't?

Whilst it is a natural process, birth may not always be as we want it. Undesired things may happen. Bad things. And, if left to their own means, they may turn the vision of what '*should have been*' into something entirely different. Something less certain. Something less safe. There may be pain and discomfort, sometimes to heights of unimagined ferocity. There can be bleeding, not just as trickles, but as flooding, soaking haemorrhage that strips the senses bare. There can be alarms and escalations, panics of concern that override any comfort of prior planning. There can be fear of failing, doubt, and a dearth of daring to keep going. The woman may feel robbed of what should've happened, violated for what did, devastated that she couldn't make it different, and betrayed by those who said they would help. There can be a catastrophic loss of worth, now or later, a sense of failure and shame that may last unabated for years to come.

Underlying so much of this is the belief that birth was meant to work and that if it doesn't, something must have happened, some fault, some agency or person has intervened to make it falter. There is blame and anger. There is distrust and bitter disappointment. Such feelings are rightful, but perhaps only to a generation that has forgotten the stories of its past. Childbirth has never been without risk.

For much of our history, having a baby was dangerous. The likelihood of dying during pregnancy was between 0.5 and 1%, which means that almost one out of every 100-woman expecting birth would not survive. Pregnant women were 10 to 20 times more likely to die than women who were not pregnant. Fortunately, such dire harbingers have changed, primarily due to innovations in hygiene and sanitation, improved nutrition and the advent of accessible health care. Maternal Mortality Rate (MMR), or the number of women who die during pregnancy and birth, is now less than 9 per 100,000 in Australia and other industrialized nations. It's poignant to note that it's not zero, bad things still happen, we can never entirely stop them, but at least they are bridled and have now become much less fearsome. This is why birth is now such a normal and desired part of life. But without such things, as in less fortunate countries impoverished by lack of privilege, death rates remain high, as much as twenty times greater than the ones we take for granted [1,2].

But Have We Done Too Much?

"In achieving the safety of childbirth, our society may have lost more than it has gained." [10].

Historically, birth was "women's business". There was no such thing as hospital care. Mothers were birthed at home, attended by older matriarchs of the family or community carers, birth attendants or midwives trained through practice to stay by the mother's side at home. Many changes have since happened, leading to vast improvements in maternity care outcomes. Perhaps holding the hand of such progress was the move to modernize birthing by taking it from the home space and bringing it to hospitals where processes and practitioners could be standardized. Here, an immediacy of care was optimized, and response to harm or complication was a mere alarm's bell away. Has it worked? If we look at the notoriety of death and morbidity, we must say yes, for, without a doubt, these have improved dramatically. But despite this, we are beginning to see more and more that such things have not come without cost. By taking women from their homes, we took them from community and country, from the safety of trusted support, and put them in sterile spaces to be cared for and treated. Hospitals were traditionally institutions of men, trained physicians who could give care but were uncaring; professional but impersonal and paternalistic. They were unsympathetic and stopped seeing women as mothers or mothers-to-be, but as patients, as cases with something wrong that needed to be fixed. Women became objects to monitor, bodies to watch with babies inside that were themselves, little more than heartbeats waiting to be born. As choice became limited, systems and processes became more ritualized, and natural rhythms ignored. We diminished nature's ability to participate, to help nurture the power and flow of a woman's body to birth safely and unencumbered. We were impatient. We forgot to trust and wait for things to unfold in their own good time. The end became the only thing that mattered. A baby born, its lungs filled with crying, its mother intact, exhausted, but whole. Alive and living and ready to go home. Did we do our best? Yes, we think so. But did we get it right? No, not entirely. There is a growing realization of harm, a revolt from doing too much and leaving too little. We are now challenged to look again at what we're doing. To re-think old models of maternity care and to change what is, into something more holistic; perhaps not a return to what it was, but a reclamation of what it could be.

Reclaiming the Normal

Birth is a time of vulnerability and opportunity. It may be an experience of mortality, of physical and emotional ardour that can empower or encumber. It may also be a time of passage, transition, opening up and allowing wonder to enfold and unfold in ways that sometimes cannot be imagined. The experience of holding a little one, the joy of self-realization and attainment of what life creates, its beauty, it's subtly, its power and healing. Part of understanding birth is to allow room for all these possibilities, knowing that whatever happens, can do so safely. There may be hurts, but joys too, and maybe that's okay. To allow one without the other has been perhaps too much to ask. People have started to say enough! They are pushing back against the confinement of labour and the coercion to medicalize pregnancy. They are reclaiming the birthing space to shield it from unnecessary intrusion. *It's not wanted*, they say. *Let it be what we want*. People are taking back the right to experience the power of birth, their birth, for themselves, in whatever way they choose. They tell us what that environment will be like. They protect it. They own it and will allow only those they know to enter, be it a midwife, a friend, a doula or any other with whom trust is shared. They're not afraid to say what will happen and what won't. They take control of their experience; they tell us how it will go and how it will end. With the advent of social media and access to information from the internet, women are finding their voice and the conviction to use it, to speak up and, if needed, to shout. They are told to claim their autonomy, their power to choose what happens to them, what they allow and what they don't. This consent or permission for care is written as a birth plan for women in labour. It is binding and allows no argument, compromise, or change. It is on her terms and hers alone. And it is her right to do so.

Is that okay? Yes. Everyone has the right to determine what happens to them. It becomes incongruous, however, when women choose to utilise such plans in hospitals; they desire the proximity of medical care, but only if needed and only then, on their terms. They tell us what things are permitted, what observations or examinations can be performed, and what interventions can be offered. They may even tell us what we can or cannot say, who can come into the room and who can't, sometimes going as far as to prevent the medical team entirely [11]. This is not new, though the passion for upholding it may seem so. We have noted the conflagrations of consent and refusal that have vexed medical compliance for many years. Patients may decline an operation or a recommended procedure such as a blood transfusion. However, we have learnt to reconcile, broadening our scope of choice to support variance and keep relationships vital and collaborative. Is birth any different? No, in many ways it is the same, except of course, for one very significant distinction. It involves a baby.

Obstetrics is not just about providing care for one person; it is about two people, a mother and her unborn child. And it is here that we find impasse. We are obliged to do what the mother wishes. We know this. We must respect her right to choose what happens and what doesn't. To do otherwise is to risk assault or, at the very least, an ethical violation of consent. It doesn't matter what we believe or what risks we might feel are incumbent; we must acknowledge her autonomy to decide for herself what she is prepared to do or have done to her. But what of the baby she carries? Unborn, it has no rights. It has no voice, so its fate is determined entirely by the mother's choices.

So, what do we do when we believe those choices may cause harm? The answer is simple; we do nothing. And why, because we cannot, we are not permitted to do so. Herein lies a disillusionment of care that thrusts deep as a thorn in the side of all who attend in witness, the caregivers; the doctors, the midwives, the second victims.

The Second Victim

What do we do when our care for one person affects the outcome of another, or more apposite, when the inability to care for one may harm the other? We are told we can do nothing. Not until the birth. Until then, we must abide by the mother's desires even if such wishes are potentially blinded or dismiss a risk that we believe significant. What do we do when we are not allowed to do what we know we should? What happens when we can't do what we're trained for or provide the level of care expected of us by peers and the community? What then? It is difficult for the woman, who may feel her choices challenged and must constantly defend them. She becomes isolated and resentful. It is difficult for the maternity team; they feel obstructed, diminished and unable to do what they must. They feel disempowered. Futile. And yet, in a hospital environment, they are nonetheless responsible. Even when no clinical harm occurs, midwives and doctors suffer from stress and anxiety for the 'near-miss' of things that could so easily have happened. And when things do go wrong, they suffer a sense of guilt and responsibility, which can be so severe that it can lead to enduring depression or anxiety and, for some, the loss of careers or even life [12].

In our discussion, we expand the term, Second Victim, to include clinicians who are disempowered and forbidden by patient consent to fulfill the duties of care normally expected of them. We acknowledge that this is not new. It becomes novel and more contentious in the practice of obstetrics, where the prohibition against action may harm not just the mother but the unborn baby she carries, who is denied the benefit of best care because of another's decisions. These fears are mocking; for they happen while we watch; a falling heart rate, thick meconium liquor, a bleed that doesn't settle, a labour that obstructs. What do we feel? It can be any number of things. Helplessness. Anxiety. A sense of impending doom. There can be the fear of reprimand or blame, for which we feel inescapably responsible.

In our case report, the patient and support persons expressed their wishes for delivery with incontestable certainty. Many of these desires were beyond the scope of recommended safe practice. She was an older lady, her pregnancy was complicated by gestational diabetes, and she had a history of Caesarean birth for obstructed labour. We could not monitor her, gain intravenous access, or take blood. We were unable to watch over her baby as we would normally do. She birthed, however, and did so the way she had hoped, vaginally and naturally. But she had a baby that required significant resuscitation. Only then, once the baby was born, could we treat it. Afterwards, in the safety of a tea room, the staff debriefed. They vented frustration over what had happened with feelings of futility and powerlessness, and of frustration from trying to balance the woman's need for control with the objectivity of safe clinical care.

(Staff de-identified)

"*Things would have been different if we could have monitored the baby.*"

"Do you think the baby will be okay?"

"I could have done more."

"*We felt like we were villains, as though it was wrong to be there or to ask to do more. But what else could we do*?"

When caregivers are involved in cases with poor outcomes, they are likely to suffer some form of anxiety that may significantly affect their quality of life and physical health. For many, job satisfaction becomes brittle. They become weary and defensive; they feel vulnerable. For some, it may force an involuntary retirement, a change in career or an inability to work because of ongoing stress [12]. When we invited feedback, we were told how important it was to talk about this, but people don't feel they can; they think they're not allowed to do so. No one wants to hear this side of the story, their side.

(Personal testimonies de-identified)

"*When it happens, I feel like I'm being forced to agree to do things I know are wrong. It's like I'm being asked to provide substandard care when mothers refuse to do what I think they should, that I know they should. How do I know? Because that's what I'm trained to do. And yet, I'm being asked to ignore these things, step back, or just do what I'm told even when I know it's wrong or it's not enough to do what's needed. But what else can I do?"*

"Sometimes I can't sleep at night. It's not just worrying about the patient; it's worrying about me. What if I get blamed or if I get de-registered? What do I do then?

"I feel oppressed when I see these things happening but can't do anything to stop them. It's like watching a train crash and not being able to help. I spend so much time trying to explain why we do things and why we want to do this or that, yet it all seems to fall on deaf ears. It's as if they've heard it all from Facebook or google, and nothing I say matters."

"The emotional toll of literally holding my breath waiting for a baby to birth, of seeing so many bad signs and being unable to do anything. Of just waiting and hoping. It's terrible. Usually, things are okay or perhaps the baby just needs extra time in the nursery. But sometimes it's worse; the baby is flat and things go crazy. I feel scared. I feel so much guilt and grief for everything I could've done. Sometimes it all just feels too much."

"It stays with you. Even when things turn out okay, and the mother goes home, I still feel it, and I know that it's going to happen again, with another mother who won't trust me, won't listen. There's no rest. There's no protection."

"What do I do when I see things happening that I know shouldn't? When I watch a baby's heart rate falling or abnormalities on the CTG becoming worse, I know that we need to do a Caesar, but the mother says no? What do I do when no matter what I say, she won't listen? I feel I can only stand there while I watch her baby struggle in front of me; I have been so scared that while I stood by doing nothing, the baby would die. I'm not scared for me, I'm scared for the baby, and I don't understand why they won't listen."

"I have loved my career, but I am told all my medical training has brainwashed me, and I won't listen, that I've got an agenda. More and

more, I'm forced to stand by and watch as people without training and knowledge make decisions for themselves and their babies that could be devastating. But I can't do anything. I have loved my career, but I think it's time to stop. I feel tired, and I feel burnt out. I'm done, and I'm tired of feeling like a bad person."

Why were they there? Because they had to be, it's their job. Why was the woman? Because she chose to, and even though she decided to be in a hospital setting, to be where trained professionals provide care [13], she decided to hold them at bay, at ransom, powerless to do anything beyond her consent. No matter whether this is right or wrong, there is a cost. There may be a cost to the baby, a price that we cannot begin to fathom, and there is a cost to us, the caregivers caught up in the ordeal of a dichotomy that defies calumny and entwines us all; midwives, doctors, and students, all inescapably caught in a drama that seems to have no end.

Conclusion

We present this case not to argue whether it was right or wrong, though we concede the language used has been emotive and, no doubt, may be read as biased or opinioned. Our purpose was to speak up for those who have been there; who have experienced this and fear that it will happen again. Our intention was to bear witness to the emotional fallout that affects those who have been there. This is rarely acknowledged. Yet we see that it afflicts people who commit their lives and professional careers to providing quality care. They are stopped from being whom they were trained to be. They are silenced. They are helpless. And then it leaves them alone, to carry their feelings unaided. They are real people and victims just as much as anyone affected by violence and threat. What happens to them? What will happen to our health service when they leave, when they can't come to work because of sickness or stress? Who will bear the responsibility for the greater tragedy of suicide and death? What is the answer? We don't know. But we venture it must begin by listening and taking care of those of us affected now. We deserve that. We all do.

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