



## Peri-FACTS

University of Rochester  
Medical Center  
Dept. OB/GYN, Box 668  
601 Elmwood Avenue  
Rochester, NY 14642-8668  
Phone: (800) 285-2366  
(585) 275-6037  
Fax: (585) 276-2080  
E-mail:  
Peri-FACTS@urmc.rochester.edu  
Web site:  
<http://www.urmc.rochester.edu/obgyn/Peri-FACTS>

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## Peri-FACTS Case #792

### Chapter Topic:

Sudden/Unexpected Death in  
Obstetrics

### This week's topic:

Resuscitation in the Birthing Room:  
Family Reactions when Joyous  
Anticipation turns to Shock

### Editor-in-Chief

James R. Woods, Jr., M.D.

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Shirley Warren, R.N.C., M.S.N.P.

### Video Production

Sean Logghe  
James R. Woods, Jr., M.D.

# Peri-FACTS

*A Multimedia eJournal  
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From the University of Rochester's  
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**This Week The Peri-FACTS  
Channel, presents: STRIP  
ROUNDS – The First in a  
Series on Fetal Heart Rate  
Terminology and  
Interpretation.**

## RESUSCITATION IN THE BIRTHING ROOM: FAMILY REACTIONS WHEN JOYOUS ANTICIPATION TURNS TO SHOCK

By James R. Woods, M.D.  
Department of Obstetrics and Gynecology  
University of Rochester Medical Center  
Rochester, NY

Learning Objectives for **Peri-FACTS** Case #792: Upon  
completion, the learner will be able to:

- Name ways in which obstetric nurses can prepare for critical-care events in an LDRP setting.
- Describe different reactions family members may have during a newborn resuscitation and describe techniques to address these reactions.
- Explain how accurate documentation of events is important in bringing closure to an acute-care event in an LDRP.

## INTRODUCTION

Picture this scenario. Your labor and delivery unit has been renovated into several new labor-delivery-recovery-postpartum (LDRP) rooms. No longer will your patients undergo labor in one small windowless room, then be moved to a delivery room with its operating room environment. Gone is the traditional "hospital" look. Instead, the birthing room is decorated with a traditional-looking bed, which can be adjusted for delivery, a chest of drawers, a mirror or

poster on the wall, and perhaps even lounge chairs or a refrigerator. All such furnishings are intended to impart a home-like atmosphere. Gone also are the traditional maternity-ward rituals of the past, such as the shaving of pubic hair, routine administration of an enema, standard episiotomies, allowance for only one family member at the bedside during labor, and worse, no family member at delivery in the operating room. You are pleased at the appearance of this new LDRP. You welcome the fact that the patient's entire family is invited to be present during the labor, and you anticipate with excitement the delivery of your first patient in this newly renovated setting. The family's cameras are clicking, and their video camera records each moment. How exciting that the entire family will be present for the joyful moment when the baby's head crowns. Soon, everyone expects to hear the new baby let out a lusty cry. He or she will be suctioned routinely, then placed on your patient's chest for warmth and immediate skin-to-skin contact. Unfortunately, your first LDRP delivery goes all wrong.

### **CASE IN POINT**

Following an unremarkable pregnancy, K.H. experiences spontaneous onset of labor at term. She and her husband arrive at a level-2 community hospital and are taken to the kind of LDRP room which is described above. K.H.'s labor has progressed normally, advancing unremarkably through an one-hour second stage. For unclear reasons, however, the baby's heart rate has begun to be difficult to pick up by auscultation. Now, K.H.'s obstetrician decides to perform a vacuum-assisted delivery, probably more out of his desire to complete the delivery, than because of any serious concern about fetal problems. After all, the fetal heart rate throughout labor has been described by the nurse who has been auscultating the fetal heart as completely normal.

### **"IN A LOT OF TROUBLE"**

The newborn's head is delivered, followed immediately by the shoulders. Then, K.H.'s baby is out. Two sentences are uttered, almost simultaneously. "It's a boy," says one of the care providers. "Why isn't he crying?" K.H. asks, sounding worried. D.H., her husband, stands there, overcome suddenly with shock. During the next few minutes, as D.H. will recall the experience later, there is a chaotic flurry of activity. A nurse tells him, "They are working on your baby. You need to concentrate on your wife." It is at this moment that D.H. stops videotaping his son's delivery (although, as he says later, he was in denial, and "I took several more still pictures.") Someone tells D.H. that his son is "in a lot of trouble." D.H. feels faint. "At some point, I remember hearing a nurse say, 'I'm sorry. There was nothing we could do.' My wife was screaming. I said, 'We need a priest,' and then I had to sit down."

### **THE TRAUMA OF UNEXPECTED EVENTS**

What you have just read was an actual event described to me by D.H., the father, three years after his stillborn son's delivery. This family since has enjoyed the successful

births of two more sons. They are a happy family, who nevertheless never will forget the trauma of their son Matthew's wholly unexpected stillbirth.

Care providers, too, do not forget the sudden, unanticipated death of a patient's baby. No one denies the indelible impression of fright and disappointment that this type of unsuspected obstetric catastrophe can make on care providers. But, the learning value of this case for obstetric nurses delivering care in a family-centered LDRP cannot be emphasized enough.

Entire books are written about the response to pregnancy loss and the process of perinatal grief.<sup>1</sup> Less emphasis is placed on that critical 20- or 30-minute period during which a family watches while a team of care providers resuscitates their baby desperately and, sometimes ultimately, unsuccessfully. It is this period of crisis, and the roles which are played by the care team, to which this **Peri-FACTS** Chapter Topic is directed.

## **WELLNESS VERSUS CRITICAL CARE**

Ironically, while the LDRP has emerged as a most visible setting for the family-oriented event of sharing in the birth of a new baby, the reaction of family members when anticipated events go wrong has not been accorded similar attention. Numerous articles exist in the literature about family reactions to observing a baby's resuscitation in the neonatal intensive care unit (NICU) and pediatric intensive care unit (PICU). Intuitively, it may be assumed that there is some overlap with comparable interventions in the LDRP. Still, the concept of illness pervades the PICU and NICU. In contrast, wellness, new life, and health define the LDRP. Concepts of sudden death or the urgent need for resuscitation among care providers in an LDRP may be more academic and less often put into practice here than they are by nurses in the NICU or PICU, which by definition, are acute-care settings.

## **PREPARING FOR THE UNEXPECTED**

Four basic concepts must be contemplated by care providers in the LDRP setting, to prepare them for untoward events in this usually non-acute-care setting. First, wellness in obstetrics can turn to critical illness quickly, transforming an anticipated happy family event into an unexpected, and consequently, more traumatic experience for a family. Second, in that transition, which may develop literally in only seconds or minutes, reactions of family members and events as they are remembered in retrospect may be unpredictable, and therefore may require that each member receive individual attention. Third, one of the care providers must assume a role as overseer, observing activities of the entire group of participants, including care providers, family members, and the patient herself. Fourth, sometime during the first few days after the experience, family members should be counseled about the events of the attempted resuscitation. In such a counseling session, individuals should be encouraged to describe what they witnessed and how they perceived the care providers' actions. The reasons for review

of all of these concepts may not be clear at first glance. Thus, the remainder of this chapter examines these issues in greater detail.

## **PREPARING FOR MEDICAL AND PSYCHOLOGIC CRISES**

Obstetrics has been described as the only normal biologic process that brings a woman into the hospital. The prevailing atmosphere generally is quite cheerful, when it is considered in the context of the other sites in a hospital. In the setting of a family-centered LDRP, it is understandable that medical care per se would feel to the patient and her family as more relaxed or casual than in fact it actually is. From patients' and their families' perspectives, this is a disarming environment which is dedicated to support the excitement and happiness of a normal birth. Unlike their mostly unsuspecting patients, though, care providers must be prepared to respond immediately to unforeseen events. A woman with undiagnosed epilepsy suddenly may have a seizure. A baby's heart rate suddenly may drop. Or a newborn may be delivered blue and floppy. To confront unexpected emergencies such as these, staff nurses must train not only to be prepared for practical responses but also to be prepared to address a specific psychosocial crisis on short notice. In certain circumstances, care providers even may benefit by running mock drills. Constant monitoring of systems, equipment, and protocols is crucial. Is newborn resuscitation equipment state of the art and easily accessible? Is a defibrillator readily available, in the event of a maternal cardiovascular collapse? (Recall that thrombosis leading to pulmonary embolism is a leading cause of maternal mortality.) Training for many types of unpredictable emergencies provides critical-care backup, in the event that, in the LDRP, the normal suddenly becomes abnormal.

## **UNPREDICTABLE REACTIONS OF PARENTS**

Reactions of parents watching resuscitation of their newborn run the full range of emotions. Some parents later describe utter disbelief, a sense of lack of reality; as if they were witnessing an event that could not possibly be happening. Others describe numbness or paralysis. Some will cry out, scream, or exhibit rage. Others, however, may project inappropriate cheerfulness, a manifestation of insulating, or momentary distancing, from such an unacceptable event.

Faced with a panoply of emotions, nursing staffs momentarily must be "all things to all people," responding supportively as the bizarre tragedy unfolds. Simply holding the father's hand later may be recalled as a significant calming gesture. Repeating a comforting sentence such as, "The doctors are working with your son (or daughter)," may help to keep parental emotions from spinning out of control, thereby deflecting the possibility of uncontrolled rage or even violent behavior. Perhaps even the phrase, "I am so sorry," will provide comfort as the resuscitation continues. Whether or not the resuscitation effort is successful, these caring phrases are remembered as a measure of the power of nursing intervention.

## **WHO IS IN CHARGE?**

Understandably, unanticipated medical events often demand instinctive but unrelated actions by care providers. Imagine that the newborn is delivered and exhibits no respiratory activity. Meanwhile, perhaps an episiotomy has been cut and is bleeding. The placenta begins to detach from the uterus, adding to the woman's bleeding. The father, witnessing his child's responses to resuscitation, may begin to panic as other care providers are summoned, while some still must focus their efforts on the mother's needs. The father's cry, "What is wrong?" often may be uttered unheard. Someone yells, "Get peds here stat." It may seem that all systems have gone haywire now.

At this moment though, some care provider has to take responsibility for oversight of all of the activities. That responsibility likely will fall to the nurse, who may need to perform several tasks, all at the same time. Does the pediatric team need supplemental or specialized equipment? If the obstetrician or midwife is helping with the resuscitation, who is following the mother or monitoring her bleeding? And, who is controlling the level and style of communication among care providers? Finally, who is documenting these events as they occur?

In the midst of a newborn resuscitation, it is common for care providers to speak in abbreviated phrases, to use shortcuts in communicating needs, cardiovascular status, or even, at times, frustration or fear. The family unwittingly becomes privy to these exchanges, although they may not understand their meanings. What they hear, how they interpret what they hear, and what they choose to remember may or may not be accurate. This selective hearing is reported frequently by families, days, weeks, or even years after they have witnessed the successful or, worse, unsuccessful resuscitation of their child.

The nurse who is attending the family must listen to these statements and even may need to decipher them during the actual event as it unfolds. Concomitantly, she must document for the permanent record each phase of the resuscitation. What time did delivery occur? What procedures were performed during the initial resuscitation? How much time has elapsed since the resuscitation was initiated? This sequence of timed, documented events can become invaluable, as the pediatrician, obstetrician, or midwife makes decisions about how long to continue the resuscitation effort, when to change to a higher level of resuscitation, or when to consider medications in addition to respiratory and cardiovascular support. Documentation of times and events also will be important when comparing the family's perception of the experience with these facts as they were documented by the attending nurse. It is the need to discuss perceptions gained by the family during a resuscitation and their comparison to actual events that underscores the importance of our fourth principle, bringing closure on the resuscitation itself.

## **REVISITING THE EVENT**

Selective hearing, misconceptions, feelings of inadequacy, threat of the loss of parenthood, rage, heart-felt pain, and depression all understandably are products of that

30 minutes when excited anticipation turns suddenly to crisis, no matter whether resuscitation of the newborn is successful or not. Years later, parents recall in vivid detail their version of the event, where people were standing, who said what, and how each care provider responded to their child's desperate needs. What measures can care providers take to ensure that most families will carry in their memories a reasonably accurate recollection of that brief but traumatic period, even if care providers cannot take away the emotional pain that such an ordeal evokes?

Much has been written about how families should be approached after a baby has died. The principles that define value for appropriate inpatient counseling techniques; gathering of mementos, role of care providers, clergy, and the funeral director, to name only a few aspects; all have been derived as a result of the personal experiences that grieving families have shared with care providers. In this field of blended psychology and biology, care receivers have taught their care providers much. (This writer, alone, has been the recipient of kind and thoughtful education by more than 500 families whom he has counseled for pregnancy loss.)

A principle that seldom is stressed, however, is that appropriate closure of the actual resuscitation is an important step in building a foundation for care during the remainder of the hospitalization, the postpartum months, and the years to follow. Irrespective of outcome, every family who experiences the crisis of resuscitation of their newborn deserves to have a thorough, honest discussion sometime in the first day or so after the event, in which details and timing of the resuscitation and issues of selective hearing or viewing can be aired. This session should involve the physician or midwife, nurse, the parents, and even extended family members, such as grandparents of the baby (a group who often are overlooked in grief and post-trauma counseling). There should be structure to the counseling. But, there should be no predetermined time limit. The family's needs should determine the length of such a session.

First, details of the labor, delivery, and resuscitation should be reviewed slowly, in terms that are understandable to the family. Then, the sequence of care providers' decisions (when and how the resuscitation was carried out, how long the resuscitation lasted, when and why it was discontinued) should be explained. Most important, family members should be asked to describe their own impressions of the event.

- Were they frightened or confused?
- Did they know the names or, at minimum, the professional roles of each of the care providers who were involved in their baby's resuscitation?
- Did they hear or observe actions that were disturbing to them?
- Did they feel that everything possible was done, or have they begun to wonder if more should have been done for the baby?
- Are they angry and, if so, where is their anger focused?

Note that questions such as these are uncomfortable to ask. The family's responses to these questions may be frightening for care providers to hear, especially in cases when parents assert that care providers could have done more to anticipate or to manage the problem. Eliciting these feelings, as frightening as they may seem in the abstract, provides a basis for building trust. Open, honest disclosure between care receiver and care provider probably is the most critical component of communication for both groups. Otherwise, when no discussion is offered, the family may become suspicious, distrusting, and angry. Lawsuits even may be a result, because of a failure to converse honestly and openly.

Bringing the entire care team together for such a counseling session serves a second and equally important function. In essence, it addresses the question, "Who cares for the care provider?" Care providers are human, too. We grieve, feel inadequate, and even feel threatened when we are humbled by medical technologies' and interventions' inability to control all events. The death of a newborn leaves no one untouched. But, with whom do we share our feelings? A combined counseling session helps to start this process. Care providers lose nothing by expressing sadness, a sense of inadequacy, or even deep grief at an unsuccessful attempt to resuscitate a newborn. These qualities underscore the fact that what we do is, in large part, more art than science. In many ways, however, human touch is the most powerful force in medicine. Medicine is a bridge between biologic science and humanity. In times of crisis such as when a resuscitation is attempted—and especially when the resuscitation fails—emotional expressions of caring add to, rather than detract from, our contributions to our patients.

## **VIDEOTAPING**

Finally, what is the role of videotaping in labor and delivery? There is no denying the fact that competition and patient requests have forced many institutions to sanction videotaping, to capture on film the audio and video records of the delivery. At your institution, you may permit this service. For the sake of balance, however, I offer an argument against routinely permitting the videotaping of a baby's birth. The ubiquitous video camera in the delivery room, in the majority of cases even, has replaced the 35-mm still "first baby picture." One could argue that the real-time recorded video is intended to capture a happy event, with all the sounds, the cheering, even the first appearance of the baby.

Unfortunately, we forget that this happy "normal process" quickly and unexpectedly can become a medical emergency. What, then, is the family's video camera's role? Certainly, it innocently was not intended to capture the true drama of a resuscitation. Fathers or grandparents mean only to herald the arrival of their family's newest member. Unfortunately, if events take a turn for the worse that videotape can be seen as a violation or invasion, which is capturing uncontrollable, unexpected events with an unknown outcome. Videotaping is a dispassionate mechanism, which preserves every action, and word performed and uttered in what can become a sudden crisis. It does not acknowledge that, during a medical crisis, care providers often must communicate

quickly and incompletely, using phrases that are caught offscreen by the audio component of the video camera. Video cameras vary also in their representation of color. All babies initially present with peripheral cyanosis as conversion from a fetal-placental to newborn circulation occurs. Misrepresentation on film, compounded by selected audio components, as care providers desperately engage in a life-and-death resuscitation, serves no purpose for care providers or family. Sadly, we live in a litigious society. At the University of Rochester Medical Center, video cameras are permitted during the labor process and after the newborn is stable. Thirty-five mm still pictures may be taken during the birth itself. We feel that this approach is an appropriate ethical balance, which recognizes the value to the family of documenting the birth process, but which also recognizes that obstetrics has a critical-care component that, when crisis occurs, first and foremost must be addressed by care providers, who thereby are unencumbered by fear of litigation or amateur photographers' misrepresentation.

## **CONCLUSION**

In summary, popularity of the family-centered birthing room reflects the public's interest in returning to the traditional social milieu of childbirth. There was a time not too long ago when births occurred within the home, with involvement of immediate family and even extended family members. In that setting, family members became accustomed to seeing critical-care or even fetal or neonatal death when adverse events arose. With the advent of hospital-based labor and delivery units, the family's role in the birth process became circumscribed and diminished. Family members could be involved to some degree if labor were progressing normally. Presented with the risk of an abnormal outcome, however, family members were ushered away to be spared the fright and chaos of a delivery, which suddenly has taken a turn for the worse.

Today, there is a paradigm shift in hospital-centered obstetric care. Bringing family-centered childbirth to the hospital is relatively new, both to providers and receivers of intrapartum care. As a consequence, issues such as a family's viewing the birth of a depressed newborn who needs resuscitation must be worked through for a new, 21<sup>st</sup> century generation of care providers. This is a process that will take time, effort, and thought. It also will require expansion of obstetric nursing skills to meet new psychosocial challenges. Properly met, the obstetric nurse can play a pivotal role in maximizing the social aspects of a family-centered birthing room, while providing leadership and oversight when the expected becomes the unexpected.

## **RELATED READING**

1. Banchner H, Waring C, and Vinci R (1991). Parental presence during procedures in an emergency room: Results from 50 observations. Pediatrics 87: 544-48.

2. Doyle CJ, Post H, Burney RE, Maino J, Keefe M, and Rhee KJ (1987). Family participation during resuscitation: An option. Annals of Emergency Medicine 16: 673-75.
3. Eichhorn DJ, Meyer TA, Mitchell TG, and Guzzetta CE (1996). Opening the doors: Family presence during resuscitation. Journal of Cardiovascular Nursing 4: 59-70.
4. Hanson C and Strawser P (1992). Family presence during cardiopulmonary resuscitation: Foote Hospital Emergency Department's nine-year perspective. Journal of Emergency Nursing 18: 104-6.
5. Heuer L (1993). Parental stressors in a pediatric intensive care unit. Pediatric Nursing 19: 128-31.
6. Johnson AH (1997). Death in the PICU: Caring for the "other" families. Journal of Pediatric Nursing 12: 275-77.
7. Miles MS and Perry K (1985). Parental responses to sudden accidental death of a child. Critical Care Quarterly 8: 73-84.
8. Seideman RY, Watson MA, Corff KE, Odle P, Haase J, and Bowerman JL (1997). Parental stress and coping in NICU and SICU. Journal of Pediatric Nursing 12: 169-77.
9. Wells EJ (1996). Assisting parents when a child dies in the ICU. Critical Care Nursing 16: 58-62.
10. Woods JR and Esposito Woods JL (1997). Loss during pregnancy or the newborn period (Ed. 1), Pitman, NJ: Jannetti Publications, Inc.
11. Woods JR and Rozovsky FA (2003). What Do I Say? Communicating Intended or Unanticipated Outcomes in Obstetrics, Hoboken, NJ: Jossey-Bass: A Wiley Company.
12. Zottoli EK (1998). Neonatal resuscitation: Making the case for family presence. Lifelines 2: 70-72.

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