The Ethics of Forgiveness after Adverse Events in Childbirth

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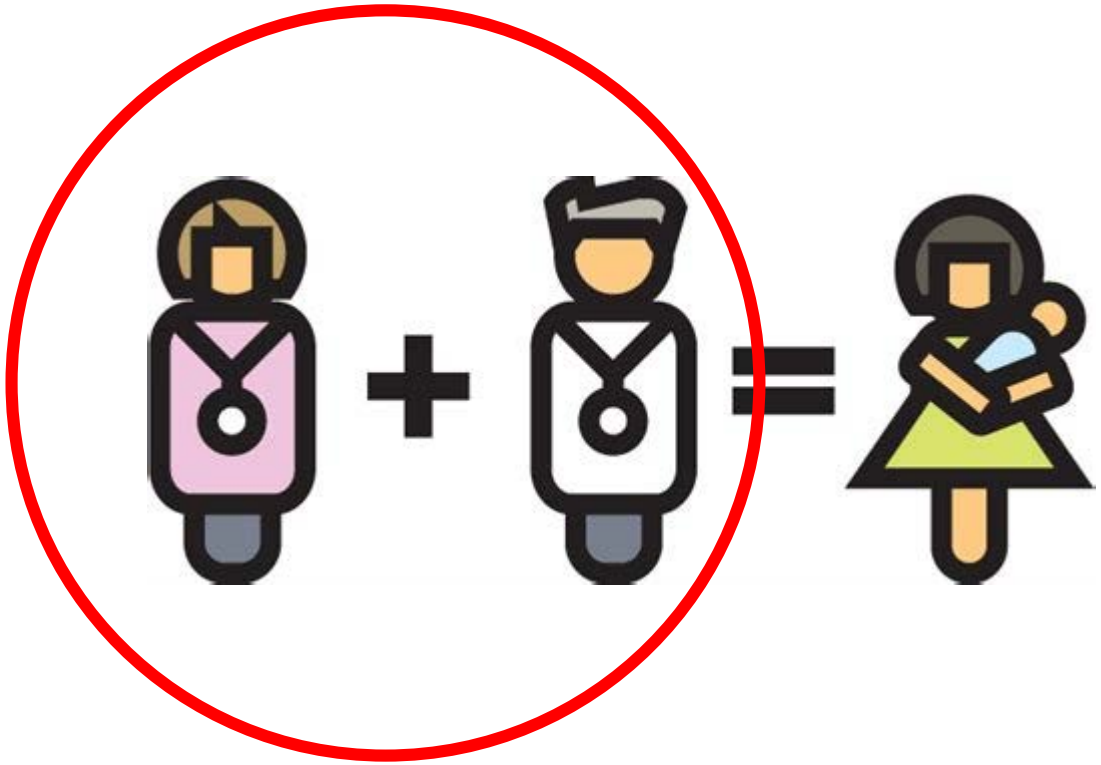
18 May 2018



CASE – Dr. Jones

Twin delivery.

After the delivery of twin I, twin II's heartbeat drops to a critical level.

Amniotomy (rupture of membranes) is performed, twin II turns into a transverse position.

Go to OR, preparations for C-section are made.

Dr. Jones decides to turn the fetus internally, pull the feet down and deliver it in a breech position (estimates time of delivery to be quicker).

The baby is born as far as the umbilicus – arms are extended and stuck.

All manoeuvres are attempted – CS is no longer an option – very heavy pull on posterior arm.

Finally twin II is delivered, alive and well, but with a limp arm – Erb's palsy.

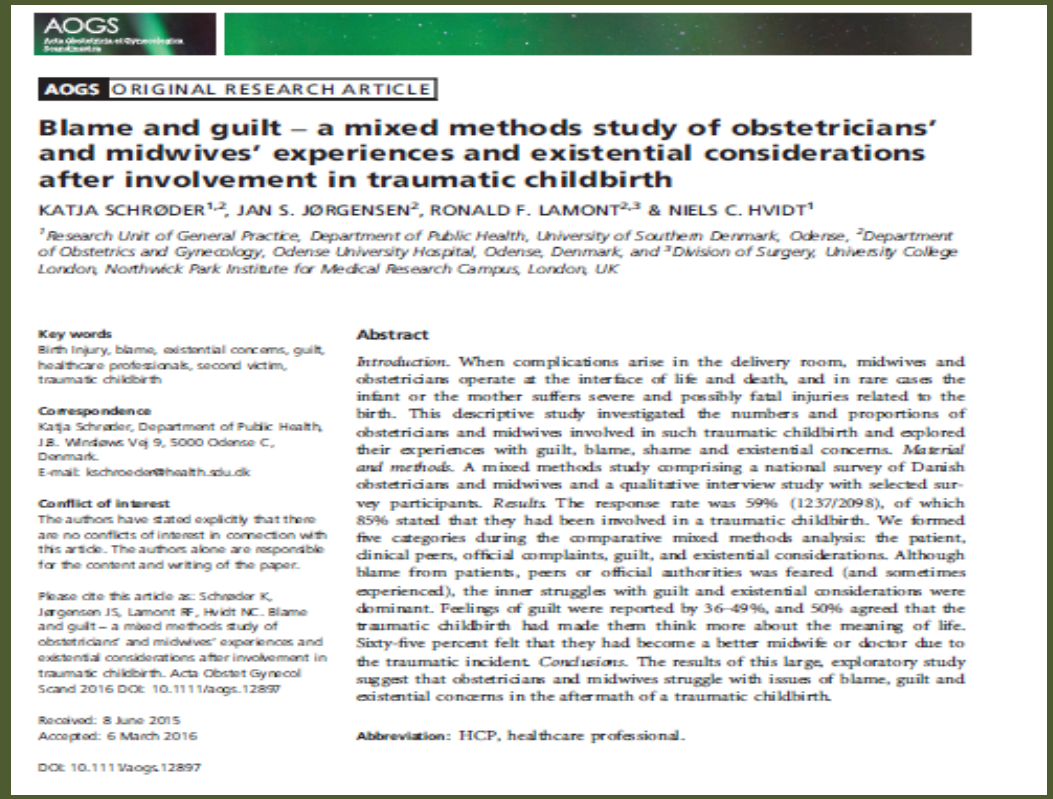
CASE – Dr. Jones

I felt really guilty … having caused this … (…) You feel like apologising many, many times. Even though you may not … be at fault really, but still … you were the one who… did it, right? *Dr. Jones*

Blame and guilt

- National survey (n=1237) and individual interviews (n=14).
- Fear of being blamed is a concern.
- Self-blame and guilt appear to dominate, even when no blame is placed.

➢ Although the current patient safety programs have promoted a more just and learning culture with less blaming and shaming, the personal feeling of guilt remains a burden for the individual HCP.



AOGS

AOGS ORIGINAL RESEARCH ARTICLE

Blame and guilt – a mixed methods study of obstetricians' and midwives' experiences and existential considerations after involvement in traumatic childbirth

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Key words
Birth injury, blame, existential concerns, guilt, healthcare professionals, second victim, traumatic childbirth

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Conflict of interest
The authors have stated explicitly that there are no conflicts of interest in connection with this article. The authors alone are responsible for the content and writing of the paper.

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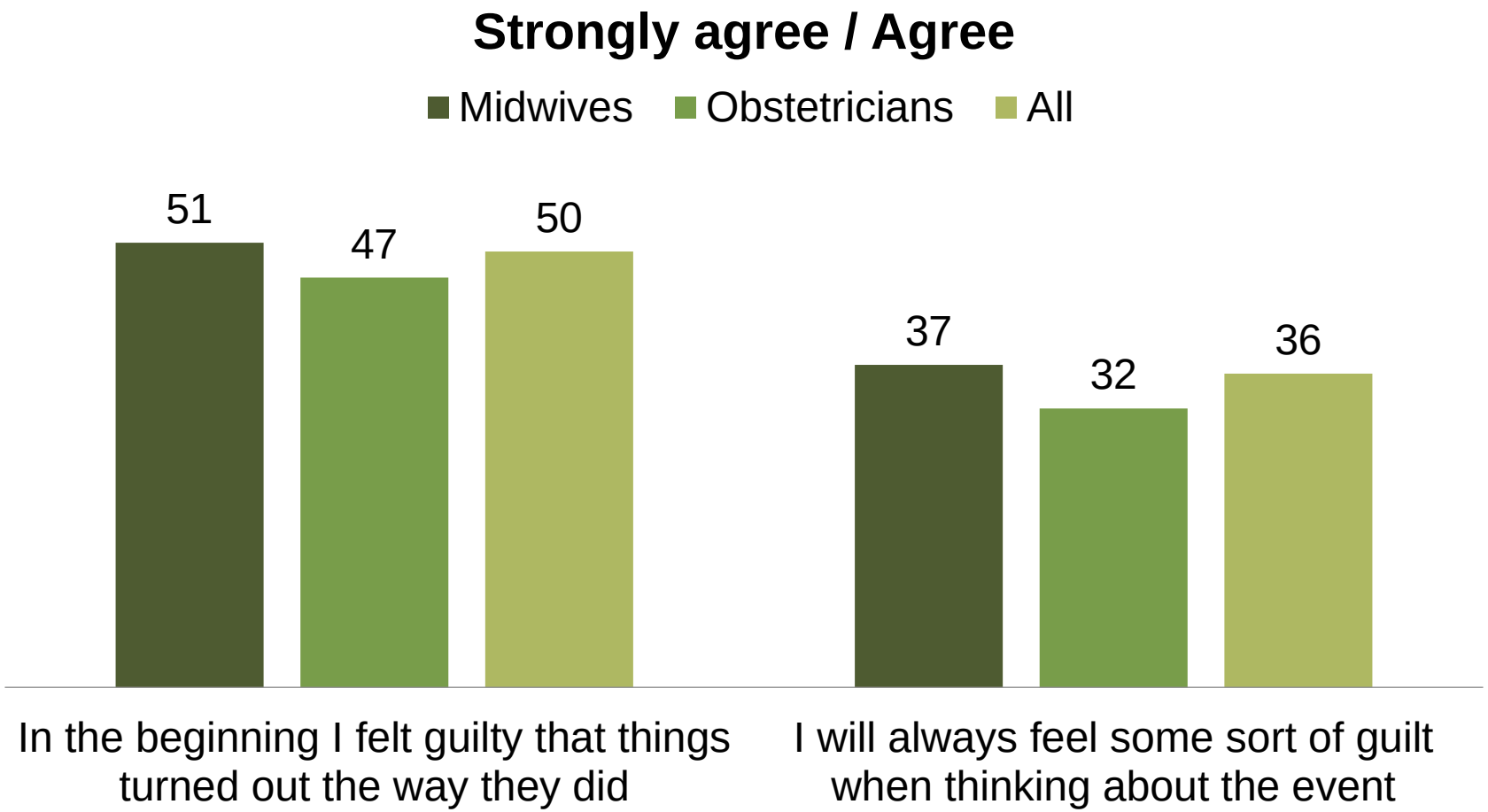
Abstract

Introduction. When complications arise in the delivery room, midwives and obstetricians operate at the interface of life and death, and in rare cases the infant or the mother suffers severe and possibly fatal injuries related to the birth. This descriptive study investigated the numbers and proportions of obstetricians and midwives involved in such traumatic childbirth and explored their experiences with guilt, blame, shame and existential concerns. *Material and methods.* A mixed methods study comprising a national survey of Danish obstetricians and midwives and a qualitative interview study with selected survey participants. *Results.* The response rate was 59% (1237/2098), of which 85% stated that they had been involved in a traumatic childbirth. We formed five categories during the comparative mixed methods analysis: the patient, clinical peers, official complaints, guilt, and existential considerations. Although blame from patients, peers or official authorities was feared (and sometimes experienced), the inner struggles with guilt and existential considerations were dominant. Feelings of guilt were reported by 36–49%, and 50% agreed that the traumatic childbirth had made them think more about the meaning of life. Sixty-five percent felt that they had become a better midwife or doctor due to the traumatic incident. *Conclusions.* The results of this large, exploratory study suggest that obstetricians and midwives struggle with issues of blame, guilt and existential concerns in the aftermath of a traumatic childbirth.

Abbreviation: HCP, healthcare professional.

GUILT


Strongly agree / Agree
Midwives
Obstetricians
All
51
47
50
37
32
36
In the beginning I felt guilty that things turned out the way they did
I will always feel some sort of guilt when thinking about the event

Guilt

You know, that feeling that I actually… maybe didn't kill that child, but may have contributed to it. *Obstetrician 2*

…I think that, what makes it really hard, is the fact that (cries)… they [the parents] *continue* to have a disabled child and all that. It doesn't go away. *Midwife 4*

We have to live with the fact that we can be guilty of something… I reckon we have to live with it. That we can be guilty of something. *Obstetrician 3*

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Guilt

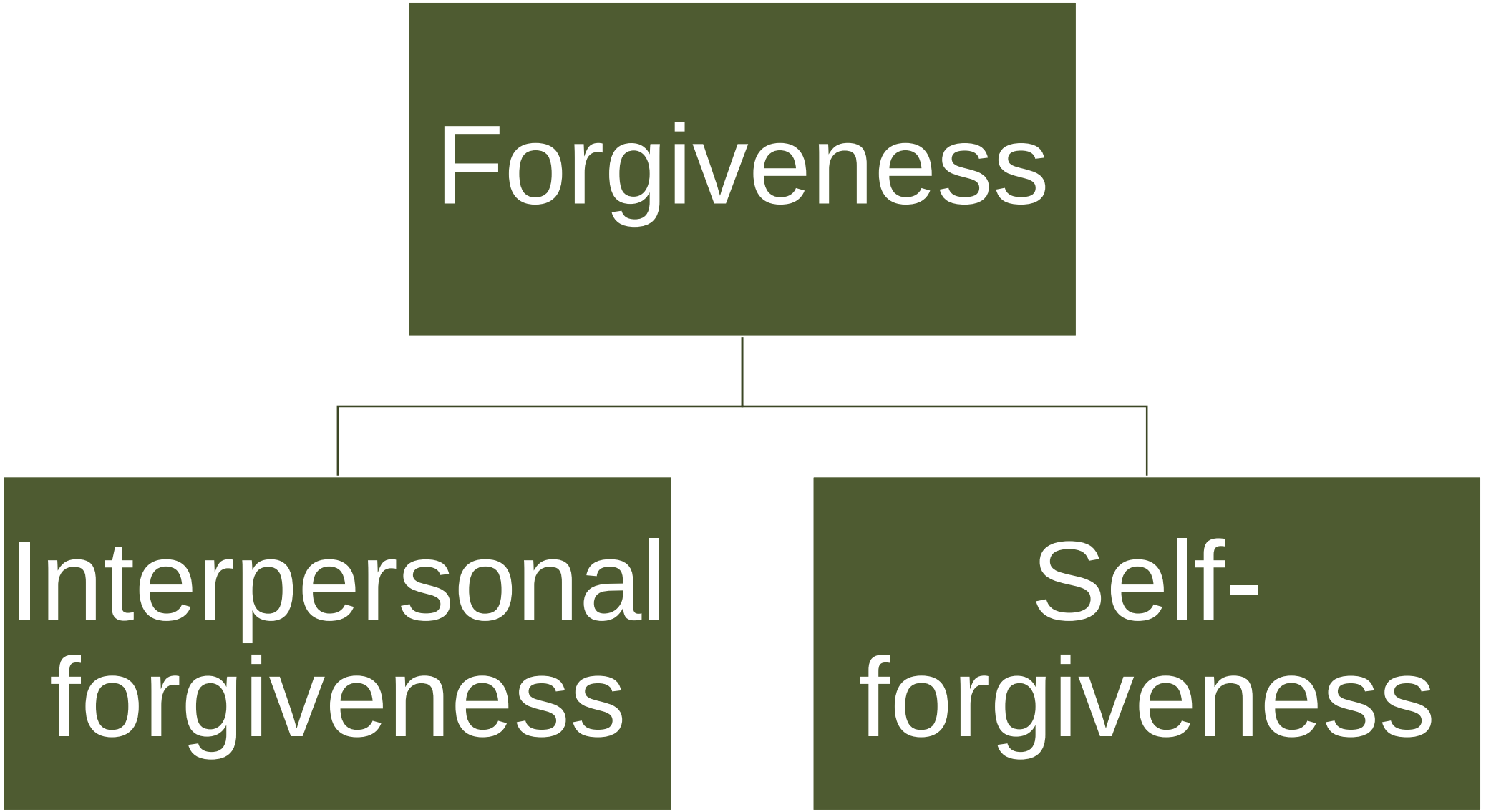
…of course it was a relief to be exonerated, but I still thought that… It wasn't like I thought "O well. Then it was nothing." Because it was still a bad outcome for that child, right? And the mother still had a terrible experience, and… and I was, at least partially, responsible for what had happened, right? *Midwife 6*

I was puzzled!

How come some of the participants felt guilty, when they had done nothing wrong and they were not blamed?

The Ethics of Forgiveness

- feelings of guilt
- uncertainties as to whether they were to blame for the incident
- difficulties in forgiving themselves.


Forgiveness
Interpersonal forgiveness
Self-forgiveness

- **Forgiveness in healthcare?**

- **How do we embrace and forgive ourselves?**

- **Why is this important?**

Self-forgiveness

A failure to forgive oneself, when self-forgiveness is due, may lead to destruction of one's capacity for agency, and even to self-annihilation (Griswold, 2007, p. 122).

Self-forgiveness restores their capability to carry on as functioning persons even after causing (…) harm or death to other innocent persons (Gamlund, 2011b, p. 125).

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Guilt without fault: A qualitative study into the ethics of forgiveness after traumatic childbirth

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ABSTRACT

When a life is lost or severely impaired during childbirth, the midwife and obstetrician involved may experience feelings of guilt in the aftermath. Through three empirical cases, the paper examines the sense of guilt in the context of the current patient safety culture in healthcare where a blame-free approach is promoted in the aftermath of adverse events. The purpose is to illustrate how healthcare professionals may experience guilt without being at fault after adverse events, and Gamlund's theory on forgiveness without blame is used as the theoretical framework for this analysis. Philosophical insight has proven to be a useful resource in dealing with psychological issues of guilt and Gamlund's view on error and forgiveness elucidates an interesting dilemma in the field of traumatic events and medical harm in healthcare, where healthcare professionals experience that well-intended actions may cause injury, harm or even death to their patients. Failing to recognise and acknowledge guilt or guilty feelings may preclude self-forgiveness, which could have a negative impact on the recovery of midwives and obstetricians after adverse events. Developing and improving support systems for healthcare professionals is a multi-factorial task, and the authors suggest that the narrow focus on medico-legal and patient safety perspectives is complemented with moral philosophical perspectives to promote non-judgemental recognition and acknowledgement of guilt and of the fallible nature of medicine.

Moral philosophical perspective I

<u>The standard view:</u>

There is nothing to forgive unless the person has deliberately done wrong to another person.

In cases where the person has done wrong, but has either a **justification** *(lawful self-defence) or* an **excuse** *(the insanity defence)* for his action, forgiveness is not the appropriate response.

In other words, we can do wrong without deserving blame for it. And when there is no blame, there is nothing to forgive.

From this perspective, self-forgiveness may not be an issue for HCPs, because they presumably never make mistakes deliberately or intentionally do harm to their patients.

Moral philosophical perspective II

The person is aware that he is not really at fault but feels guilty nevertheless, and in such cases it is reasonable to suppose that the person feels *as if* he is morally responsible for the event.

If the HCPs feel *as if* they have done something wrong, then

> *(…) there is simply no consolation for them to be found in the thought that what they did was not really their fault* (Gamlund, 2011, p. 124).

<u>The alternative view (Esben Gamlund):</u>

There is **conceptual space for forgiveness** in certain cases where a person has an excuse or a justification for his action, and he may still seek forgiveness.

Conceptual space for forgiveness

Disagreement about the <u>justification</u>

***(…) not all cases of justification are of the kind where reasonable agreement exists (…)* (Gamlund, 2011, p. 113).**

Mitigating <u>excuses</u>

Two principles:

1. Primum non nocere (First, do no harm).
2. Physician's oath/ Hippocratic Oath, *(…to use my skills with diligence and care for the benefit of society and my fellow men…)*

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Conceptual space for forgiveness

Disagreement about the justification

Mitigating excuses

To regard a conduct as excused is to admit that the conduct was wrong but to claim that the person who engaged in the conduct lacked substantial capacity to conform his conduct to the relevant norms and thus was not fully a responsible agent. (Gamlund 2011, p.109)

Case – Midwife Price

Evening shift on the labour ward.

Prolonged and painful labour. Epidural with several top-ups, only minor pain relief.

Very slow progress of labour over the next 3 hours.

Junior doctor and consultant obstetrician are both called to help assess the woman, but they are both very busy in the ER.

Midwife Price senses that the patient in the ER is more in need of medical treatment than the laboring woman.

→ Consults the doctors over the phone: Oxytocin drip is prescribed.

Finally, the baby is delivered but unexpectedly shows signs of severe asphyxia and later examinations show permanent cerebral damage.

The consultant sees the CTG trace a few hours after the delivery and comments that the drip should not have been increased, due to too many contractions.

Conceptual space for forgiveness

Disagreement about the justification

Mitigating excuses

To regard a conduct as excused is to admit that the conduct was wrong but to claim that the person who engaged in the conduct lacked substantial capacity to conform his conduct to the relevant norms and thus was not fully a responsible agent. (Gamlund 2011, p.109)

"I *excuse* myself with the fact that it was *so* busy on that shift. But then again… that's not really an excuse, is it?"

Moral philosophical perspective III

Standard view: In cases where the person has done wrong, but has either a justification *(lawful self-defence) or* an excuse *(the insanity defence)* for his action, forgiveness is not the appropriate response.

→ Not your fault = no forgiveness.

Alternative view: There is conceptual space for forgiveness in certain cases where a person has a justification or an excuse for his action, and he may still seek forgiveness.

→ Not your fault, but your sense of guilt is acknowledged and forgiveness is appropriate.

This is a patient safety issue!

Learning from our mistakes is vital, and in order to provide safe high-quality healthcare, the health and wellbeing of the HCPs is an essential aspect to consider.

Our study showed that 50% felt some sort of guilt because of what happened during an adverse event in childbirth. Consequently, the impact of guilt and the need for forgiveness deserves more awareness and attention in midwifery and obstetrics.

Embracing guilt and feelings of guilt should be an inevitable part of the medical, midwifery and nursing profession. This approach would contribute to the learning environment in a just organisation, where HCPs legitimately can express the impact they have experienced in the aftermath of a traumatic or adverse event.

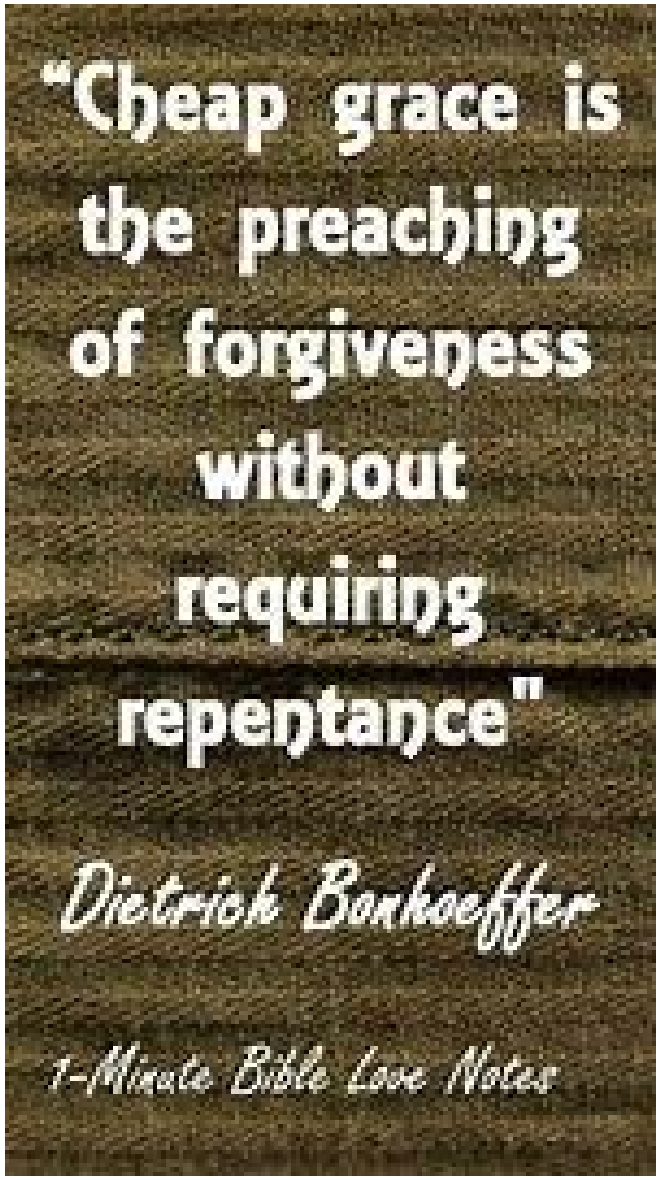
Self-forgiveness – how?

The journey is a passage from being stuck in the past, holding on to illusions about who one is, to coming to terms with oneself as a fellow human being, like others, imperfect but no longer alone. (Bauer et al. 1992, p. 160)

Genuine self-forgiveness

“(…) self-forgiveness is rightly suspected of abuse. […] It all too easily degenerates into self-interested condonation or excuse making.” (Griswold, 2007, p. 122).

Genuine self-forgiveness includes sincere acknowledgement of the wrongdoing and acceptance of responsibility.



Medical harm

From error to forgiveness

Error
Disclosure
Apology
Repentance
Forgiveness

(Berlinger 2005)

Interpersonal forgiveness

In cases of medical harm, a cheap-grace approach on the part of professional caregivers, including clinicians, chaplains, social workers, or pastors, may also place pressure on injured patients and their families to forgive automatically—by reminding them, in subtle or not-so-subtle ways, that “good” people are “forgiving”, or by assuring them that offering forgiveness will bring them “closure” or by telling them that, after all, nobody *meant* to harm them (…) *(Berlinger 2005, p. 82)*

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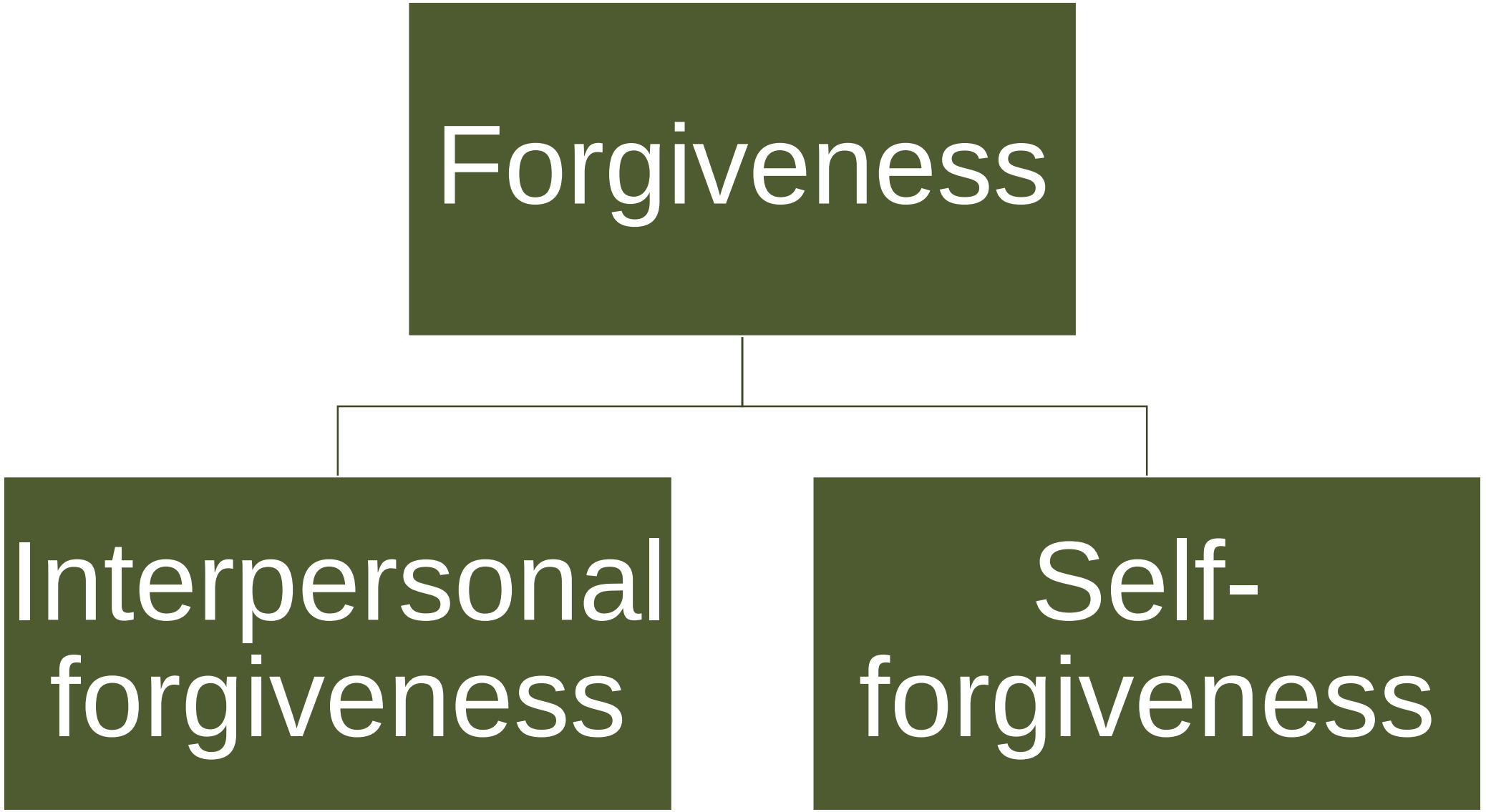
Forgiveness
Interpersonal forgiveness
Self-forgiveness

The buddy study

- a peer support programme for healthcare professionals after adverse events

- Acknowledgement of the impact of adverse events
- Inclusion of every single employee – responsible leadership and organisation
- The relation is essential
- Building on already established ressources
- Research based

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Thank you for listening

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