

An obstetric story

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In July 1977, having finished medical school, internship, a residency in obstetrics and gynecology, and a one-year fellowship in family planning with training in the treatment of sexual dysfunction, I went to work as the junior associate in a well-respected local OB/GYN practice in southern California. One night six weeks into my new role as private practitioner, I was on call for the group when one of our pregnant patients near term was brought to the hospital by her husband.

I was there to meet her when she arrived. A young primigravida near term, she appeared acutely ill with markedly elevated blood pressure and abdominal pain that I quickly realized wasn't labor. Physical examination and lab work confirmed that she had severe preeclampsia with HELLP (*hemolysis, elevated liver enzymes, low platelets*) syndrome, a potentially fatal complication of pregnancy in which red blood cells break down, the liver and other organs swell, liver function is altered, and the number of platelets falls, increasing the risk of hemorrhage. A major risk associated with HELLP syndrome is hepatic rupture with massive intraperitoneal bleeding. I had seen one case of such catastrophic rupture

while in residency, and both mother and baby had died. None of the six other OB/GYNs in the practice I had joined had ever seen a case with hepatic rupture; nor had any of the other OB/GYNs in my community.

The definitive cure for severe preeclampsia with HELLP syndrome begins with ending the pregnancy, but I feared that my patient would not withstand induction of labor. I also knew that to proceed with a Caesarean section at that moment might well prove fatal for her, so I opted for an initial effort at stabilization with standard measures for treating preeclampsia: dark room, bed rest, antihypertensive medication, anticonvulsant therapy to try and prevent eclamptic seizures, and something for pain. My plan was to give her six hours to settle down and then do the Caesarean section. I was frightened, but I also knew that panic wasn't going to help.

The night passed with agonizing slowness and was complicated by the need to manage another labor and delivery that, fortunately, went well.

Finally, at 7 AM, I decided that it was time to deliver the baby. While transferring her to the operating table, she suddenly went into shock and, from my reading about the few cases that had been reported, I was certain that she had ruptured her liver and was bleeding internally. I put out a call for a general surgeon, the anesthesiologist

crashed her, and I got the baby delivered in under two minutes from skin to placenta. It was of no avail. The baby, deep in shock, could not be resuscitated and was pronounced dead almost immediately.

Mom did better. With the surgeon working on her exploded liver, the anesthesiologist pouring unit after unit of blood, platelets, and cryoprecipitate into her, and me working on her massively hemorrhaging uterus, we managed to get her under good enough control to make it to the ICU.

I had now been up for around thirty hours. One of my associates sent me home to get some sleep and took over her care. Shortly after I left, however, he had to take her back to the operating room for a hysterectomy because of uncontrolled bleeding secondary to a consumptive coagulopathy, a well known complication of HELLP syndrome. Postpartum, she developed Sheehan's pituitary necrosis requiring comprehensive hormone replacement but, at least, I took some consolation knowing that she had survived.

She continued to see me for care for nearly nine months. Then, her husband's business failed and, in financial straits, the couple filed a lawsuit against me for wrongful death of the infant, the allegation being that I should have intervened several hours earlier to deliver the baby. The expert brought in by my malpractice attorneys

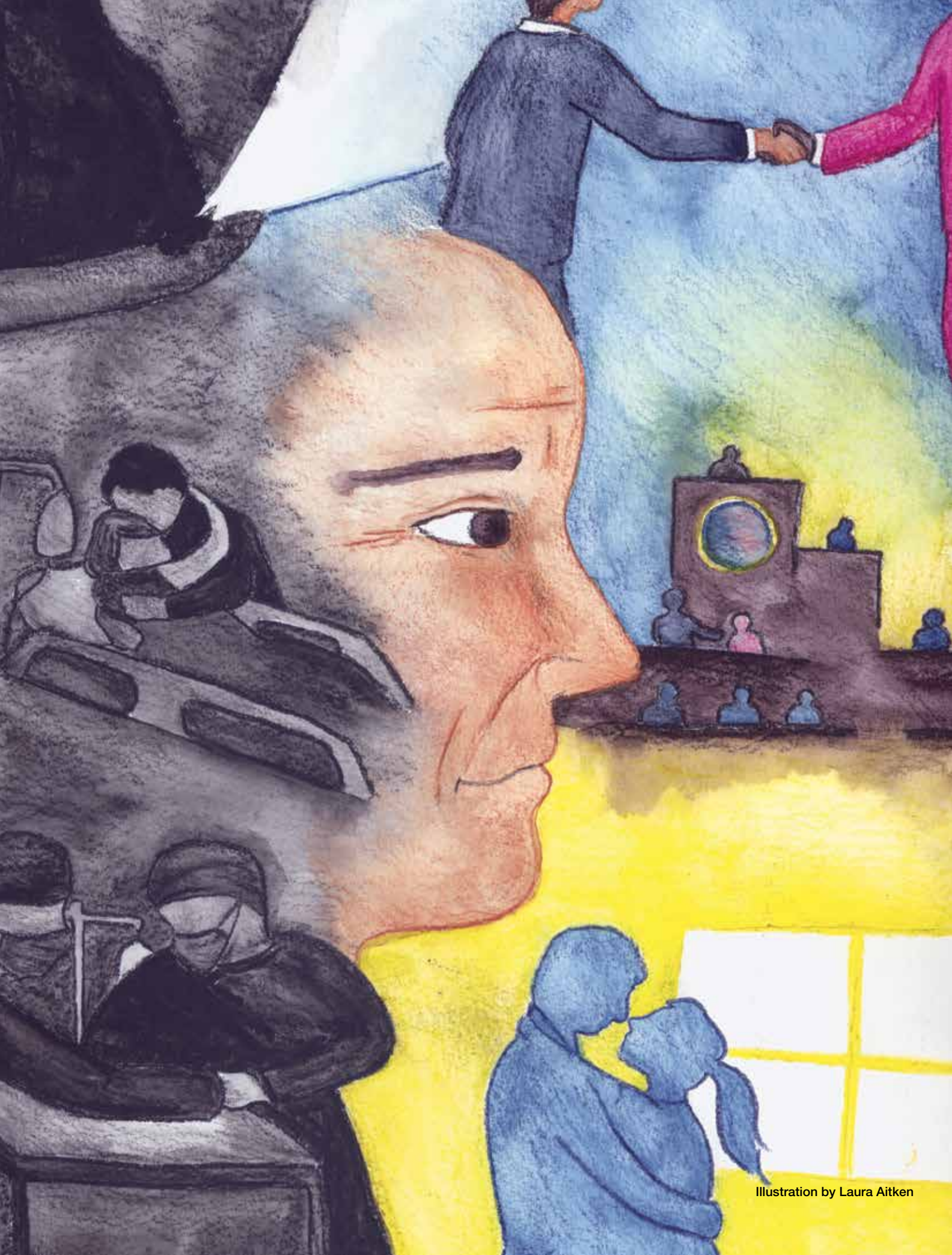


Illustration by Laura Aitken

predictably disagreed, noting that regardless of the timing of delivery, both perinatal and maternal mortality rates were high in pregnancies complicated by HELLP syndrome with hepatic rupture. The case dragged on for three years until, a couple of days before the trial was to begin, I received a call from my malpractice attorneys to tell me that a former professor and mentor had agreed to testify in court that my care had been below acceptable standards. I was devastated and yielded to pressure from the attorneys to settle the case. Of the six figure settlement, the woman's attorneys got forty percent.

Shortly after the settlement was inked, it came out that the plaintiff's attorneys had lied, and my professor had not agreed to testify but had, in fact, told them that my care was entirely appropriate. Despite my insistence that the case be reopened, my attorneys refused, saying they didn't want to risk putting the woman on the stand and getting enough jury sympathy to swing the verdict against me.

Shattered emotionally, I spent the next five years in deepening depression and self-doubt, unable to find the joy I'd hoped for in my chosen specialty, paranoid in my interactions with patients, and ultimately seriously enough impaired to consider suicide. My 2 AM drives down a twisting mountain road from home to the hospital for laboring patients were filled with thoughts of simply driving over the edge to escape the suffering I thought I could no longer bear. Finally, though, frightened and realizing that while suicide might be an answer for me, it would be no answer for my wife and young daughters, I erupted into the open and told my wife I couldn't go on and would have to leave practice, even though I had no well-thought-through idea of what I would do next.

As we talked, I realized that I had had no real understanding of how my depression had been affecting her—but her immediate willingness to support my decision made it clear that I had

been dragging her down with me in ways I would never have wished. Over the next year and a half and despite many tense days, she stood by me as I worked to move my career in some meaningful direction without throwing away my years of training.

I will not detail all of the intervening steps that led, progressively, to the role I have played for the last nine years that culminated in my recent retirement, but this final professional role has been, in many ways, my salvation and the way I finally have been able to put away the experience that has haunted me so terribly for so long.

In 1999 I went to work for a large health care insurance company and, although it wasn't the role I had been hired into at the outset, after several years I segued into a full time position doing quality management and, specifically, addressing grievances filed by insured health plan members, problems with impaired or incompetent physicians, and defending physicians and medical facility staffs wrongly accused by patients and their supporters of incompetence, ethical breaches, or other clinical or administrative inadequacy. My role has led me to interact with medical experts in a variety of fields, with (and against) attorneys both admirable and despicable, with hospital, outpatient urgent care, and surgery facilities, and with pharmacies, all with the goal of finding truth while being fair to all, and trying to develop and implement appropriate corrective actions when necessary.

While it is certainly true that many grievances filed against doctors, nurses, and other medical professionals have merit and require intervention to prevent ongoing and future harm, it is equally true that many accusations made by patients are groundless, born of anger over imagined or trivial slights, disappointment over unpreventable adverse outcomes and, not least, billing disputes. Being in a position both to advocate for patients with legitimate grievances and to

defend providers wrongly or unfairly accused of substandard practice or unethical conduct has enabled me to redirect what was disappointment and disillusionment with the reality of my personal experience in medical practice into the meaningful pursuit of fairness for both patients and providers caught up in situations that can often spiral wildly out of control.

In so doing, I have come to accept that the vast majority of patients are well intentioned even when wrong in their allegations, and that physicians and other medical personnel overwhelmingly strive daily (and nightly!) to perform their duties at the very highest levels of both ethics and clinical competency. But it is a fact that there are outliers: sometimes patients, who can often be angry, depressed, unreasonable and vindictive, and sometimes providers, who may be insensitive, aloof, and unfortunately lacking in skill or deficient in their personal conduct or communication skills. It has become my good fortune, in the end, to be someone privileged to seek a reasonable path through the maze of human behavior complicating the doctor-patient relationship. I now view human nature in a way I formerly did not, and because of this I have overcome the bitterness, hurt, and depression that destroyed my early career.

Finally, I've evolved enough to feel compassion without anger for the young couple whose baby was lost over the course of that horrific night and morning nearly forty years ago, people whose ability to have a mutually conceived baby was lost forever, whose source of income was suddenly cut off, and who lashed out at me in grief and all-too-human anger and frustration as their world collapsed around them. I do not know whether they have ever found sufficient peace or understanding to forgive me, but I have forgiven them, and I am happy.

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