Addressing the needs of families who have experienced birth trauma, creating policies for improving maternal outcomes

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Trauma and Birth: Multidisciplinary Approaches to Prevention and Healing
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Perinatal Support of Washington PATTCh

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Learning Objectives

1: To provide an overview of the rise in maternal mortality and morbidity in the U.S.

2: Briefly summarize research on childbirth complications, and the resulting trauma that can affect everyone involved

3: Introduce the Maternal Safety Bundle: “Support after a Severe Maternal Event” (www.safehealthcareforeverywoman.org)

4: Identify resources for hospital unit leaders to assess patients, families and participating clinicians’ need for additional information, support and/or treatment

Maternal mortality

Personal and social tragedy
Sentinel health event
Indicator of social and economic values
Reflects political commitment (or lack thereof) to women and their families

US MMR high, and getting worse

<table>
<thead>
<tr>
<th>Year</th>
<th>MMR Rate (per 100,000 live births)</th>
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<tbody>
<tr>
<td>1990</td>
<td>15.8</td>
</tr>
<tr>
<td>2000</td>
<td>17.7</td>
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<tr>
<td>2015</td>
<td>25.4</td>
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Source: The Lancet. Credit: Rob Weychert/ProPublica

Disclaimer

This presentation was prepared by Christine H. Morton, PhD in her personal and professional capacity.

The opinions expressed in this presentation are the presenter's own and do not reflect the view of her employer, the California Maternal Quality Care Collaborative (CMQCC) at Stanford University.
What is driving the rise in Maternal Mortality and Morbidity?

- Media narratives typically reflect medical perspective that women’s characteristics are most contributory
  - “Older, fatter, sicker”
  - No prenatal care
  - Addiction and mental health
- Some add social determinants of health factors
  - Low-income
  - Less educated
  - Unmarried
  - African American

Why isn’t pregnancy getting safer for women in the United States? CDC Webinar 1/30/14

JAN 2014

We cannot forget this is about real women and their families
Where are their stories?
How can we learn from their deaths?
How can we honor their lives?

SHIFTING THE NARRATIVES

Lost Mothers

An estimated 700 to 900 women in the U.S. died from pregnancy-related causes in 2016. We have identified 120 of those cases.

by Nina Martin, ProPublica, Emma Glennon and Alessandra Pintos, special to ProPublica
July 25, 2017

Dominance of Provider QI Opportunities: Hemorrhage and Preeclampsia

- California Pregnancy Associated Mortality Reviews
  - Missed clinical warning signs/risk factors: abnormal vital signs, pain, altered mental status/lack of planning for at risk patients
  - Underutilization of key medications and treatments
  - Difficulties getting physician to the bedside
  - “Location of care” involving Postpartum, ED and PACU
- University of Illinois Regional Perinatal Network
  - Failure to escalate care, high risk status

Present in >95% of cases

Present in >90% of cases

**Why Maternal Mortality Matters**

- **Approx. 700-900 Pregnancy-Related deaths/year**
- **1-2% or 50,000/year**
- **~10% or 500,000/year**


**Severe Maternal Morbidity in the U.S., 1993-2014**

- **Severe Morbidity**
- **Significant Complication**
- **US births ~4,000,000/year**

**Persistent Racial-Ethnic Disparities in U.S. Maternal Outcomes**

- Rate of maternal death 3-4 times higher for Black women
  - Independent of age, parity or education
  - Higher rates of morbidity and cesarean among Black women

**Racial Equity in Birth**

- Black Women Birthing Justice
  - A landmark human rights report based on 100 birth stories from Black women

**Background - Building Consensus**

- ACOG-CDC Maternal Mortality/Severe Morbidity Action Meeting occurred in Atlanta - November 2012
- Participants identified key priorities:
  - Core Patient Safety Bundles
    - Obstetric Hemorrhage
    - Severe Hypertension in Pregnancy
    - Venous Thromboembolism Prevention
  - Supplemental Patient Safety Bundles
    - Maternal Early Warning Criteria
    - Facility Review
    - Patient, Family and Staff Support

- 6 multidisciplinary working groups were formed
Severe Maternal Events

- Many definitions
- At minimum
  - Transfusion of ≥4 units of blood products
  - Maternal ICU admission
- Expanded list from CDC may include:

<table>
<thead>
<tr>
<th>Severe Maternal Morbidity Indicator</th>
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<tbody>
<tr>
<td>1. Acute myocardial infarction</td>
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<tr>
<td>2. Acute renal failure</td>
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<tr>
<td>3. Adult respiratory distress syndrome</td>
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<tr>
<td>4. Anemia</td>
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<tr>
<td>5. Cardiac arrest/ventricular fibrillation</td>
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<tr>
<td>6. Disseminated intravascular coagulation</td>
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<tr>
<td>7. Eclampsia</td>
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<tr>
<td>8. Heart failure during procedure or surgery</td>
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<tr>
<td>9. Hemorrhage</td>
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<tr>
<td>10. Hemorrhage due to atherosclerosis disorders</td>
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<tr>
<td>11. Hemorrhage due to pulmonary embolism</td>
</tr>
<tr>
<td>12. Hemorrhage due to severe anemia</td>
</tr>
<tr>
<td>13. Hepatitis</td>
</tr>
<tr>
<td>14. Shock</td>
</tr>
<tr>
<td>15. Stroke</td>
</tr>
<tr>
<td>16. Still birth with pregnancy</td>
</tr>
<tr>
<td>17. Thrombotic embolism</td>
</tr>
<tr>
<td>18. Transfusion</td>
</tr>
<tr>
<td>19. Venous thromboembolism</td>
</tr>
</tbody>
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Patient, Family and Staff Support Work Group

Diverse representation and perspectives

<table>
<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
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</thead>
<tbody>
<tr>
<td>Cynthia Chazzotte, MD, FACOG</td>
<td>Montefiore/Bronx - NY</td>
</tr>
<tr>
<td>Donna Montalto, MPP</td>
<td>New York ACOG</td>
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<td>Christine Morton, PhD</td>
<td>ACOG/CMQCC/Stanford University - CA</td>
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<tr>
<td>Ellen Trigun</td>
<td>Premchampa Foundation</td>
</tr>
<tr>
<td>Miranda Klassen</td>
<td>Anesthetic Fluid Inflammation Foundation</td>
</tr>
<tr>
<td>Andrea Cowan, MD, PhD</td>
<td>CDC, Division Reproductive Health - GA</td>
</tr>
<tr>
<td>Diana Cheng, MD, FACOG</td>
<td>Maryland Dept. of Health</td>
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<tr>
<td>Catherine Kuhl, RN, CNM</td>
<td>AWHONN</td>
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<tr>
<td>Michelle Fleetham Hall, EBD</td>
<td>Xavier University - OH</td>
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<tr>
<td>Dana Cortina</td>
<td>Pace of New York</td>
</tr>
<tr>
<td>Michele Davidsson, PhD, CNM, CNM, RN</td>
<td>George Mason University - VA</td>
</tr>
<tr>
<td>Deborah Kazmierski, CNM, DNP</td>
<td>Frontier Nursing University - KY</td>
</tr>
<tr>
<td>Jodi Shaefer, RN, PhD</td>
<td>ACOG - NFIMR Coordinator</td>
</tr>
<tr>
<td>Ryan Hamren</td>
<td>Tara Honn Foundation</td>
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<tr>
<td>Steve Pratt, MD</td>
<td>SOAP - HI Foundation Boston</td>
</tr>
<tr>
<td>Gloria Buchmann, MD</td>
<td>OB Chair, Rutgers – NJ</td>
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Supporting Patients, Families & Clinicians

- Resources to support patients, family and staff
- Culture where patients are encouraged to speak up
- Assessing, recognizing and responding to emotional trauma
- Communication about severe event

National Partnership for Maternal Safety: Maternal Safety Bundles

“Every birthing facility should have updated policies and trained staff to address…”

- Obstetric Hemorrhage
- Preeclampsia / Severe Hypertension
- Prevention of Venous Thromboembolism in Pregnancy
- Maternal Early Warning Criteria
- Facility Review after Severe Maternal Event
- Support after Severe Maternal Event (adopted 2015)

The bundles represent outlines of recommended protocols and materials important to safe care BUT the specific contents and protocols may be individualized to meet local capabilities.

We use a variety of terms

- None of which capture the totality of women’s experience
  - Near miss
  - Near death
  - Serious complication
  - Severe maternal morbidity
  - Or how women label their experience
  - Traumatic
  - Unexpected
  - Ordeal

Kristen Terlizzi, Acreta survivor, NAF co-founder
Psychological impacts of maternal morbidity

- The prevalence of PTSD profile and PTSD symptoms up to 2 years postpartum is higher among women who experienced maternal morbidity (Furuta, Sandall and Bick 2012:20)

- Childbirth health care practitioners were often unaware of PTSD symptoms that emerged several months later (Furuta et al. 2013)

Research on Women’s Experience

- Common themes
  - Women seek to understand what happened to them, and to understand how it might have been prevented
  - Women seek to connect with others who share & understand their experience
  - Women consider short- and long-term health implications as well as future childbearing
  - Not receiving adequate information about their condition and recovery (short & long term, physical & emotional)
  - Feeling grateful to health professionals for the life saving care provided to them & their babies
  - Few receive postpartum mental health referrals

E.g., after significant postpartum hemorrhage

- 20% of women (N=206) did not receive care that consistently met their needs for acknowledgement, reassurance, and information while in the hospital, and
- 37% believed the hemorrhage might have been prevented with different care.

What is Medical Trauma?

“Medical trauma is a trauma that occurs from direct contact with the medical setting, and develops through a complex interaction between the patient, clinical staff, medical environment, and the diagnostic and/or procedural experience that can have powerful psychological impacts due to the patient’s unique interpretation of the event”

(Hall & Hall, 2016)

Implications of Undetected Medical Trauma

- Patient: Multiple crises, including physical, emotional, psychological, spiritual, existential, relational, health (medical avoidance)
- Family: Context of near-loss
- Staff: Implications of no clear protocols; powerlessness; emotional toll; fear of legal repercussions; miscommunication
- All: No support, no closure
Trauma in maternity care affects clinical staff too

Secondary trauma experienced by nurses and midwives
• 35% of L&D nurses reported moderate to severe levels of secondary traumatic stress (Beck and Gable, JOGNN 2012; 41(6):747-60)
• 17% of midwives (Australia) met criteria for PTSD after witnessing abusive care (Leinweber et al, Women and Birth 2017; 30(1):40-45)

Burnout among obstetricians
• OB-GYN was 30th out of 31 specialties in terms of career satisfaction leading to significant professional distress (Kravitz RL et al., Obstet Gynecol. 2003; 102(3):463-470)
• 50%-89% of OB residents have burnout; significantly associated with career choice dissatisfaction and depression (Becker JL et al, AJOG. 2006;195:1444–1449).

Healing Clinicians
What is the “Second Victim”?

• Defined as a health care provider (HCP) involved in:
  • Unanticipated adverse patient event
  • Medical error
  • Patient-related injury
  • HCP becomes victimized in the sense that he/she is traumatized by the event

• Second victim feels:
  • Personally responsible for unexpected patient outcomes
  • They have failed their patient
  • Second-guessing their clinical skills and knowledge base

Clinicians – the “second victim” of medical errors

• 3-fold increase in depression
• Increase in burnout
• Decrease in overall quality of life
• Feelings of distress, guilt, shame may be lasting and occur regardless of stage of training

The “third victim”

Patients who are cared for subsequently, while the team is still impacted by the earlier adverse events, may be subject to distracted care and medical errors, and have been called “third victims”
Readiness – 1
Develop a unit-based protocol that includes resources for supporting patients, their families (including non-family support), and staff after a severe maternal event.

Readiness – 2
Establish a facility-based multidisciplinary response team that integrates clinical staff and mental health professionals.

Readiness – 3
Provide unit education on protocols and conduct unit-based drills (with post-drill debriefs) on patient, family, and staff support after a severe maternal event.

Readiness – 4
Develop a unit culture where patients, families, and staff are informed about potential risk factors and are encouraged to speak up when they feel concern for patient well-being and safety.

Recognition – 1
Perform timely assessment of emotional and mental health status of patients, their families, and staff during and after a severe maternal event.
- PTSD Screening Tool
- Experience of Medical Trauma Scale
- Secondary 7- Lifestyle Effects Screening
Recognition—2

Build capacity among staff to recognize signs of acute stress disorder in patients, their families, and staff after a severe maternal event.

**KEY TIP:** Use tools that specifically address medical trauma.

Response - 1

Provide timely and effective interventions to patients, their families, and staff during and after a severe maternal event.

Response - 3

Offer support and resources to patients, their families, and staff after severe maternal events.

If we recognize and assess for medical trauma, we give patients the best chance at regaining psychological health following a medical event – By adopting new protocols and tools, we may be able to prevent severe psychological consequences of medical trauma for all involved.

Identification, Assessment, & Intervention are key to helping everyone.

Response

Communicate the condition with the patient and her family, when appropriate, after a severe maternal event.

Christine H. Morton, PhD

SafeHealthCareForEveryWoman.org
State Perinatal Quality Collaboratives

Hover over a state in the map below to see their status or click on a state to visit their website.
Local hospitals
Identify, connect, ask and engage with OB nurses and medical leadership:

- What is the Early Elective Delivery Rate?
- What is the Cesarean birth rate among First Time, Low Risk Mothers at Term (NTSV)?
- What is the VBAC rate?
- What quality improvement initiatives are they working on?
- Do they have the Maternal Safety Bundles from National Council on Patient Safety in Women’s Health Care?
- Toolkits from CMQCC?

Resources for Women, Families
For Traumatic Childbirth Experiences

- PATTC http://patch.org/
  PATTC is a collective of birth and mental health experts dedicated to the prevention and treatment of traumatic childbirth. Resources for women, families and health care providers, including a comprehensive Traumatic Birth Prevention & Resource Guide

For Traumatic Medical Experiences (not birth specific; and for clinicians and patients)

- MITSS (Medically Induced Trauma Support Services)
  http://www.mitreall.org/ is a non-profit organization whose mission is “To Support Healing and Restore Hope to patients, families, and clinicians impacted by medical errors and adverse medical events.”

Resources for Health Care Providers

- University of Missouri second victim provider support program: www.missourisecondvictim.org
- Resources from AHRQ website: www.ahrq.gov/resources/25968e3893833561.html
- Toolkit for staff support from MITSS (Medically Induced Trauma Support Services) www.mitreall.org/toolkit-for-staff-support-for-healthcare-providers.html
- Canadian Disclosure Guidelines published in 2008 www.patient znalization.org/guidelines/digests/isick-what-should-it-be-

Selected Bibliography


Dedication
In loving memory of Carrie Helen Ashley
b. 11/21/79 ...d. 06/05/17
age 38
Mother of Jason Jr (3.5 years) & Charlie (6 months)
Daughter, sister, wife, family, friend
my cousin

Christine H. Morton, PhD
Thank you. Questions?