ORIGINAL ARTICLE

A PHENOMENOLOGICAL STUDY OF OBSTETRICIANS' LIVED EXPERIENCES IN MANAGING HIGH-RISK OBSTETRIC CASES

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Background: The study examines the experiences of obstetricians handling high-risk cases, such as postpartum haemorrhage, antepartum haemorrhage, uterine rupture, and sepsis, in a resource-limited tertiary care hospital in Pakistan. **Method:** The study utilized a qualitative phenomenological approach to explore the experiences of obstetricians managing high-risk obstetric cases in a tertiary care setting in Pakistan. An open-ended questionnaire was administered to 10 obstetricians, experienced in managing high-risk emergencies, and explored key areas such as the clinical challenges faced, coping mechanisms employed to manage stress, and their views on necessary systemic changes. The data gathered was analysed using Colaizzi's phenomenological method. **Results:** Obstetricians reported a heavy emotional burden, worsened by their frequent encounters with maternal and neonatal deaths, and a lack of access to mental health services. Systemic issues, such as delays in lab tests, not enough ICU beds, bureaucratic obstacles, and inadequate blood bank support, often delayed care and increased clinical risks. Despite these difficulties, clinicians used informal coping methods like peer support, teamwork, and following protocols. Participants highlighted the need for non-punitive feedback systems, regular emergency drills, decentralizing low-risk deliveries, and integrating mental health services for staff. **Conclusion:** The findings stress the urgent need to make healthcare systems more compassionate by recognizing provider stress and implementing structural, psychological, and procedural changes. This research deepens the understanding of obstetric practices in low-resource settings and provides insights for policies aimed at improving maternal outcomes and clinician well-being. While the study is limited by being conducted at one site, it sets the stage for further exploration into healthcare professionals' experiences in low-to-middle-income countries.

Keywords: Obstetricians' experiences; High-risk cases; Postpartum haemorrhage, Antepartum haemorrhage, Uterine rupture; Maternal healthcare; Emotional stress

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INTRODUCTION

Maternal health is a vital indicator of a nation's overall health and the effectiveness of its healthcare system. High-risk obstetric cases, such as postpartum haemorrhage (PPH), antepartum haemorrhage (APH), uterine rupture, and sepsis lead to significant maternal morbidity and death worldwide. These issues disproportionately affect low- and middle-income countries (LMICs) like Pakistan.[1] Despite efforts to enhance maternal healthcare, Pakistan's maternal mortality ratio (MMR) is around 186 deaths per 100,000 live births[2] which is significantly higher than the global average. This situation underscores the need to better understand the systemic, institutional, and personal factors that influence care in high-risk obstetric situations.

Most of the current literature on maternal health in Pakistan and other LMICs mainly focuses on quantitative data like incidence rates, treatment effectiveness, and system performance indicators.[3] While this information is important, it often does not reflect the complex, subjective experiences of front-line healthcare providers, especially Obstetricians who make critical decisions within healthcare systems that operate under limited resources in health care system. The emotional challenges, ethical dilemmas, and systemic frustrations faced by these professionals are rarely studied in depth. Addressing this gap is essential because the well-being of obstetricians directly affects the quality of maternal care in emergencies[4].

High-risk obstetric conditions, such as PPH, APH, uterine rupture, and maternal sepsis, can develop quickly and require immediate action. Postpartum haemorrhage causes around 27% of maternal deaths worldwide. Sepsis is a significant factor in maternal deaths, especially in regions with

poor hygiene and limited access to antibiotics. In Pakistan, handling these complications is more difficult due to inadequate facilities, slow referrals, and a lack of training for healthcare workers in peripheral areas.[5]

The urgency of these conditions puts a lot of pressure on obstetricians to act quickly and effectively. However, in low-resource hospitals, especially in rural areas of Pakistan, delays in getting blood transfusions, surgical support, or neonatal resuscitation seriously affect care. In these situations, an obstetrician's role goes beyond clinical duties.[6] The clinical demands of high-risk obstetric cases are compounded by serious professional and psychological challenges. Obstetricians in Pakistan regularly work long hours under immense pressure often without adequate support. They face legal, ethical, and reputation risks if outcomes are poor, even when those outcomes stem from systemic issues rather than personal mistakes.[7] International literature is increasingly addressing the "second victim" phenomenon, where healthcare providers suffer emotional trauma after adverse clinical outcomes.[8] However, such accounts are mostly unrecorded and unaddressed in Pakistan.

Additionally, the sociocultural context adds further complexity. In patriarchal societies, female obstetricians might encounter extra gender-based discrimination or feel pressured to juggle family responsibilities with high-stakes clinical duties.[9] These stressors often worsen due to a lack of institutional mental health support or professional counselling. As a result, obstetricians often suffer a silent, cumulative toll on their emotional well-being and job satisfaction.

While previous research on obstetrics and maternal health has made important advances in understanding clinical pathways and improving emergency care protocols[10,11] little is known about how obstetricians personally experience these challenges. Phenomenological inquiry is a suitable approach to uncover the lived experiences of these professionals. This method helps explore how obstetricians interpret their work, cope with trauma, and evolve their personal and professional identities through repeated exposure to high-pressure situations.[12]

Phenomenology has been increasingly used in healthcare research to understand the subjective aspects of care giving.[13] Studies that investigate the experiences of nurses, surgeons, and general physicians have shown that emotional labour, resilience, and professional identity significantly influence care delivery.[14] However, similar studies focused on obstetricians in LMICs, particularly in crisis-prone areas like Pakistan are scarce. Addressing this research gap could lead to policy interventions that consider the realities of healthcare providers' experiences.

By examining the experiences of obstetricians handling high-risk cases in low-resource settings, this study provides important insights into maternal healthcare. Understanding how these professionals see their roles, the challenges they encounter, and the coping methods they employ can serve multiple purposes. First, it can help create training programs that better prepare clinicians for both the technical and emotional sides of emergency care. Second, it can guide policies aimed at better working conditions and offering mental health support for healthcare workers. Finally, by highlighting the emotional and ethical challenges of obstetric care, this research can encourage a greater appreciation for the need to support front line workers beyond just performance metrics and patient outcomes. The research aimed to develop a rich, specific understanding of how obstetricians interpret their experiences within the unique sociocultural and institutional conditions of low-resource settings rather than generalizing findings across all healthcare providers. The specific objectives of the study were:

- To explore the lived experiences of obstetricians managing high-risk cases like postpartum haemorrhage, antepartum haemorrhage, uterine rupture, and sepsis in a tertiary care hospital setting.
- To identify the systemic and operational challenges faced by obstetricians, especially in terms of limited resources, inadequate staffing, and high patient loads in public healthcare facilities.
- To understand the coping mechanisms and personal strategies obstetricians use to handle psychological stress, professional fatigue, and emotional burnout linked to frequent critical emergencies.
- To provide evidence-based recommendations for developing institutional support systems, mental health interventions, and context-specific training programs aimed at enhancing professional well-being, clinical preparedness, and maternal outcomes.

MATERIAL AND METHODS

This study used a qualitative phenomenological approach to explore the experiences of obstetricians managing high-risk obstetric cases in a resource-limited tertiary care setting in Pakistan. Given the complex and emotional nature of these situations, phenomenology is a suitable method for uncovering the meanings, emotional challenges, and coping strategies of healthcare professionals in such contexts. The research design was chosen to gain insights into how obstetricians perceive and experience their roles during critical emergencies. Phenomenology, based in existential and interpretive frameworks, is effective for exploring human experiences as they are lived, not just measured. This design allows for examining emotional, psychological, and contextual details that quantitative methods cannot capture.

The study was conducted in the Obstetrics and Gynaecology Department of MCHC (Mother and Child Health Centre) in Abbottabad, a tertiary care

hospital in northern Pakistan. This location is suitable because it frequently handles high-risk cases like postpartum haemorrhage, antepartum haemorrhage, uterine rupture, and maternal sepsis. The hospital serves a large area with many patients and limited specialized resources, making it an ideal setting for exploring the core phenomena of this study.

Purposive sampling method was used to recruit ten obstetricians who were experienced in managing high-risk emergencies. The inclusion criteria included: -

- Currently working in the obstetrics department at MCHC, Abbottabad.
- Direct involvement in managing high-risk obstetric cases.
- Demonstrated readiness to provide informed consent and participate in the research.

Participants were selected to ensure diversity in terms of roles (e.g., senior consultants, assistant professors, postgraduate residents) and gender, where possible. This diversity will enrich the understanding of how different levels of responsibility and experience shape clinical and emotional responses.

Data was collected using structured open-ended questionnaires which were administered to participants, focusing on their experiences in managing high-risk obstetric cases. The questionnaire explored key areas such as the clinical challenges faced, coping mechanisms employed to manage stress, and their views on necessary systemic changes. Each session lasted approximately 15–20 minutes and provided in-depth insights into the respondents' lived experiences within resource-constrained healthcare settings.

The data gathered was analysed using Colaizzi's phenomenological method[15], a respected framework for analysing lived experiences. The method includes the sequential steps including Transcription, Extraction of Significant Statements, Formulation of Meanings, Theme Clustering, Exhaustive Description,

Fundamental Structure and Member Checking

Ethical Considerations

Each participant received an information sheet and was asked to sign an informed consent form before data collection begins. This outlined the study's objectives, the voluntary nature of participation, and the right to withdraw at any time. All personal identifiers were removed from transcripts and reports. Pseudonyms were used in the analysis and publications to protect anonymity. Audio recordings and notes were kept in password-protected digital files accessible only to the researcher. Since the study explored sensitive topics, participants had the option to pause or skip parts of the questions. Mental health support services were offered if needed.

RESULTS

Using Colaizzi's phenomenological method, four main themes emerged from the analysis of 10 structured open-ended questionnaires with obstetricians at MCHC, Abbottabad. These themes reflected the emotional, professional, and systemic realities of managing high-risk obstetric cases in a low-resource tertiary care setting.

Theme 1: Emotional Turbulence and Psychological Strain

All participants reported experiencing a significant emotional burden when handling high-risk cases, especially when outcomes were poor. The unpredictability of obstetric emergencies, along with the responsibility of saving both mother and baby, created intense psychological pressure.

"One of my booked patients had seven miscarriages. She finally had a healthy baby, but five hours after delivery, the baby became cyanotic and died. This incident had a very emotional impact on me."

Others shared the emotional trauma of losing patients or making life-altering decisions like hysterectomy.

"I managed a prim gravida with PPH and despite every effort to save her uterus, I had to remove it. It was a physical and emotional trauma for me, but the patient survived."

For some, the emotional challenge lingered even after the case was over.

"There are no institutional policies for support. Mostly, I talk to my colleagues. That helps."

Theme 2: Systemic Challenges and Resource Constraints

Resource limitations were often noted as a barrier to effective care. Delays in lab reports, unavailability of blood products, and a lack of ICU or NICU beds frequently compromised patient outcomes.

"Working in a setup with limited resources. Delays in admission, investigations, and intervention at every step."

"Blood bank support is not adequate, and we don't have a separate blood bank for obstetrical patients."

Participants also mentioned institutional bottlenecks, like the Sehat Sahulat Program (SSP) paperwork, which could lead to dangerous delays.

"Treatment gets delayed due to SSP procedure. Availability of medicines is time-consuming."

Even in critical moments, administrative barriers could increase clinical risk.

"Blood was arranged on a no-donor basis after involving hospital administration, as attendants were not responding to the urgency."

Theme 3: Professional Resilience and Coping Mechanisms

Despite the psychological burden, obstetricians described various coping strategies that helped them deal with the frequent exposure to critical situations.

"Teamwork and peer support help to cope with the stress."

"I rely on thorough preparation and following protocols to stay calm and focused during emergencies."

Others found comfort in post-case discussions, sharing lessons learned:

"We discuss with each other about the things we are struggling with. This helps us cope."

Many emphasized that over time, stress tolerance becomes part of their professional identity:

"I am very much used to coping with the stress, especially having peer support and the guidance of seniors available round the clock."

Theme 4: Recommendations for Systemic and Institutional Support

Obstetricians offered various suggestions to improve the management of high-risk cases, mainly focused on systemic reform, better training, and team-based preparedness.

"Upgrading primary and secondary care centres is needed, so tertiary care can efficiently manage high-risk patients."

"Regular simulation drills and team training improve confidence in real-time crises."

"Clear protocols and good communication among team members are essential."

Many stressed the need for a non-punitive culture around incident reporting and clinical audits:

"Incident reporting and risk management in a non-blaming way, followed by audit, can help us do better."

They also advocated for psychological services for clinicians:

"Emotional support should be provided by trained personnel like a psychologist."

Training & Experience: While some obstetricians felt well-prepared due to years of experience, junior staff and residents pointed out gaps in hands-on emergency training.

Sociocultural Factors: One account revealed the tragic intersection of obstetrics with domestic violence, showing how broader societal issues affect clinical outcomes:

"A patient came with burn marks and bruises from domestic abuse… she collapsed during the Caesarean, and we couldn't save her."

Teamwork as a Buffer: Nearly all accounts described a competent and cooperative team as a major buffer against emotional collapse and clinical burnout.

DISCUSSION

This phenomenological study explored the experiences of obstetricians managing high-risk cases. Four main themes arose: emotional turbulence, systemic resource constraints, professional coping mechanisms, and institutional recommendations. These findings highlighted the emotional and organizational aspects of maternal care that are often overlooked in policy and research focused mainly on clinical outcomes.

A recurring theme in participants' narratives was the intense emotional burden linked to managing life-threatening obstetric emergencies. Several obstetricians discussed emotional distress from adverse outcomes, such as maternal or neonatal deaths, despite their best efforts. This aligns with the "second victim phenomenon," a term describing healthcare providers who deal with psychological trauma following medical crises.

In Pakistan, where maternal mortality remains high, this emotional burden is intensified by repeated exposure to high-stakes situations. The participants' experiences echo findings from a study[16] demonstrated that clinicians often bear the emotional weight of their choices, especially under pressure. This highlights a significant gap in healthcare systems: while emotional resilience is expected, institutional mechanisms for psychological support are still lacking.

The results clearly show that systemic limitations such as delays in blood availability, a shortage of ICU beds, and bureaucratic delays due to insurance schemes like the Sehat Sahulat Program (SSP) often undermine the quality of care. These concerns mirror findings from a study, which identified critical gaps in maternal care infrastructure and emergency readiness in public-sector health facilities in Pakistan.

Participants' frustrations about delayed lab investigations and poor coordination with support departments (e.g., anaesthesia and pathology) point to broader systemic inefficiencies. According to study, Pakistan's healthcare governance is often fragmented, with misaligned incentives and underfunded tertiary care services, particularly in maternal health. The absence of a dedicated obstetric blood bank and ICU beds increases clinical risk and demoralizes staff who feel they are facing challenges without adequate resources.

This study confirms that these issues are not just logistical; they carry deep emotional and ethical implications for obstetricians, who understand that preventable delays can mean life or death.

Despite the challenges, obstetricians displayed considerable resilience. Many relied on peer support, teamwork, and protocol adherence to stay grounded

during emergencies. These findings align with research on healthcare resilience, highlighting the importance of social support and reflective practices in reducing burnout.[17]

Interestingly, while formal institutional support systems for emotional debriefing were lacking, informal peer networks served as a key buffer against stress. As a study notes in phenomenological research, coping often exists within relational and cultural contexts, and participants' reliance on teamwork reflects a culturally resonant way to respond to occupational stress in collectivist societies like Pakistan.

However, the lack of structured psychological interventions, counselling, or post-incident debriefing raises concerns about the sustainability of this resilience. Without formal emotional support, clinicians may become desensitized, withdrawn, or prone to mistakes over time.[18]

Obstetricians proposed a variety of practical suggestions, many of which align with global best practices in strengthening maternal health systems. For instance, the focus on simulation drills and emergency preparedness training reflects WHO recommendations for boosting provider confidence and reducing preventable maternal deaths.[19]

The call to upgrade primary and secondary care facilities so that tertiary hospitals can focus on high-risk cases fits with the three-delay model proposed by Thaddeus[10], which identifies delays in receiving appropriate care at a facility as a major contributor to maternal mortality. Strengthening lower-tier healthcare could reduce referrals and improve triage efficiency.

The suggestion for non-punitive incident reporting systems aligns with the global shift towards just cultures in healthcare, where learning rather than blame is prioritized.[20] Moreover, participants' desire for structured feedback mechanisms ("sandwich technique") reveals a willingness to improve continuously, as long as there are psychologically safe environments to do so.

Finally, the repeated emphasis on mental health support, including psychologists or counsellors for obstetricians, signifies an important step towards humanizing healthcare. As Mealer noted, clinicians in high-risk fields, such as critical care and obstetrics, are susceptible to post-traumatic stress and need institutional acknowledgment and support.[21]

This study contributes to the limited body of phenomenological research in South Asian maternal healthcare contexts. By using Colaizzi's method, the research effectively captured the authenticity of each obstetrician's narrative while also synthesizing shared meanings across cases. The findings support the key assumption of Interpretivist paradigms: that healthcare professionals are not just passive recipients of clinical guidelines, but active, emotional, and meaning-making agents within sociocultural systems. This approach goes beyond technical evaluations of maternal healthcare and highlights the subjectivity of care—a vital aspect often left out of policy discussions.

The findings of this study suggest urgent and complex implications for healthcare policy and institutional practices in maternal care settings, particularly in low-resource areas like Pakistan. First, there is a pressing need to create psychological support structures within tertiary hospitals. Given the emotional toll faced by obstetricians managing high-risk cases, institutions must integrate organized counselling services, routine stress debriefing sessions, and emotional well-being protocols. These steps could help reduce burnout, lower clinical errors, and improve retention of skilled professionals.

Second, systemic preparedness needs to be enhanced. Participants pointed out the lack of ICU beds, delayed lab results, and limited access to blood products as barriers to effective emergency management. Hence, urgent investments are necessary in dedicated obstetric ICUs, 24/7 operational blood bank services, and streamlined diagnostics to ensure timely intervention and better maternal outcomes.

A third implication is the importance of task-shifting and decentralization. Overloaded tertiary centres should not be responsible for all obstetric cases. By strengthening primary and secondary care units to handle routine and low-risk deliveries, we can reduce unnecessary referrals. This allows tertiary facilities to focus their resources and expertise on complex, high-risk cases. Decentralization can also help reduce staff fatigue and improve triage efficiency.

In addition, institutions need to focus on training and building capacity. Regular simulation drills, updated emergency response protocols, and coordinated team training can greatly improve clinician confidence and readiness. This kind of preparation leads to less panic during crises and encourages more organized decision-making under pressure. Finally, a cultural shift is necessary in how we provide clinical feedback and learn. Hospitals should adopt a non-punitive approach to incident reporting. This encourages open reflection and ongoing improvement. Implementing blame-free audits and constructive feedback can create a safer and more supportive work environment. Ultimately, this boosts both provider morale and patient safety. All these implications offer a guide for policymakers and healthcare administrators to enhance the quality of obstetric care and the well-being of those who deliver it.

Limitations and Future Research

While this study offers valuable insights, it is limited by its sample size and focus on a single site. The

findings may not be applicable to other settings, but they are rich in context. Future research could consider a multi-site approach or use mixed methods to combine findings with clinical data. Additionally, exploring patients' viewpoints alongside clinicians' accounts could improve the understanding of systemic gaps and human impact.

CONCLUSION

Obstetricians reported significant psychological strain, especially when maternal or neonatal outcomes were poor, which was made worse by limited institutional support. Systemic barriers, such as delays in diagnostics, a shortage of ICU beds, and bureaucratic obstacles, often prevented timely interventions, adding to their emotional stress. Despite these challenges, many clinicians relied on peer support, teamwork, and adherence to protocols as ways to cope. However, lack of formal support systems may lead to long-term burnout. Participants called for reforms, including mental health services for staff, emergency preparedness training, decentralized care, and non-punitive incident reporting. These findings stress the importance of recognizing and addressing the emotional and structural issues faced by frontline providers. Enhancing institutional support can improve maternal outcomes and help clinicians cope in high-risk environments.

AUTHORS CONTRIBUTION

HJ: Literature search, study design, data collection. AK: Proof reading. AI: Data analysis, write-up. SAK: Data interpretation. MK: Data collection. JS: Proof reading.

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