Nancy Fitch: "Humanity isn't machines, you know"

Narrative 3 of the Marathon Maternity Oral History Project

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Aaron Orkin MD MSc MPH CCFP **Sarah Newbery** MD CCFP FCFP

In 2008, we interviewed women about their experiences of childbirth and maternity care in Marathon, a rural community in northwestern Ontario. This narrative is one of a series of stories that resulted from the Marathon Maternity Oral History Project. All of the narratives in this series were edited from the interview transcripts, then reviewed and approved for publication by the women involved. We invite readers to see the accompanying research paper for more on the Marathon Maternity Oral History Project.[1]

I'm Nancy Fitch, I'm a family doctor in Marathon.

My first delivery here was a 15-year-old delivering her first baby. At transition, she looked at me with such fear in her eyes. I can remember—this is gonna make me cry—I can remember holding her face in my hands and just saying, "You can do this." That's embarrassing because it means I wasn't protecting the perineum at the time. She went on to push the baby out without difficulty.

That experience blew my mind in so many ways. It's hard to break your prejudices about the problem of teenage pregnancy, and then to be in a situation where it's so powerful. What that teenager was doing was, philosophically, a great experience. We were connected as two humans; do you know what I mean? It was just so—I guess just a meaningful connection. I'm not looking just for a job. I'm looking to do something that's meaningful, and I had experienced a moment in medicine that had profound meaning. I think I was on a high from that for weeks. That was my first delivery.

Honouring the strength and power of women

There are different approaches to medicine; some people approach it more science, and some more art. I'm more art and intuition, and that's not common, I think. I knew from the outset that labour interested me. In the labour room, there's a whole lot of art going on, a whole lot of intuition-based decision making and relating. I think the reason is a natural feminism: believing and honouring the strength and power of women over centuries to deliver babies and parent babies. I see it as a monumental achievement that woman after woman after woman is doing day after day after day. I feel drawn to participate in that achievement. Women have been doing this for centuries, and that power is kind of a force in itself. When I talk about being motivated by the art of medicine over the science, I feel the strongest factor at work for me in the labour room is belief in this power. I believe a woman is in charge of her labour experience, and if it's within my realm to contribute to her autonomy and choice in the labour experience, then I'm going to choose to support her wish.

There's something to be thankful for about the practice in which I work. I lose no energy defending my position. As a clerk, I knew I was going into family medicine. I remember sitting at the nurses' station in a labour ward. The nurses had paged for some help. They heard some footsteps coming down the hall and one of the nurses looked and said, "Oh, it's only the family medicine resident." It was at that point that I realized I wanted out of centres where family medicine had an aura of inferiority to other medical specialties. There's a cultural tendency to expect a generalist to be mediocre at many things. I would challenge that by saying that being a generalist enhances the practice of most things. Being interested in many things keeps the mind alive and curious and active. That feeds excellence, I think. You're not bored as a generalist.

Rural obstetrics is in trouble in Canada: centre after centre is losing obstetric service provision. I believe—well, I am hopeful—that rural obstetrics will manage to survive in Canada forever. I certainly wouldn't stay in a community for more than a few years if I couldn't be practising obstetrics. I'd be somewhere else. I wish I could do more, partly for skills, partly for meaning. Less than 5 a year makes me uncomfortable. In a slow year, I may only get 5 deliveries. Even a good year would be 10. I'll attend 10 or 12 from attending other colleagues' deliveries.

There is awareness that being able to deliver in Marathon is a gift, but the times are still close enough to women being able to deliver rurally anywhere. I think that women continue to expect it. [Another community in the region] gave up obstetrics services. It just took a group of physicians to say, "We're not comfortable providing obstetrics," and that was that. Women were

told to go to Thunder Bay. That would mean having to find accommodation for a couple of weeks. Often their partners are working, often they have small children. Sometimes they're working themselves at 38 weeks. That requires a whole lot of organization to go and sit and wait. You're not comfortable, and basically just waiting for the baby to come, psychologically, that's not a great setup for labour.

"What about an obstetrics doctor per month?"

We were analyzing some of the causes of rural physician burnout. Obstetrics, unfortunately, was listed as one of them. When you cover for your own patients, you are on call for your term patients at 37 weeks, because they could go at any time. We actually noticed that one of our providers was on call for 38 weeks one year. That's just the way his deliveries panned out. We identified that limitation on your freedom as one of the causes of rural burnout. In a brainstorming session, one of our physicians threw out, "What about an obstetrics doctor per month?"

We decided to give it a try. The nurse calculates the due date and sets up monthly appointments with the obstetric physician who is covering the entire month for women with that due date. That system we devised ourselves, created ourselves. It was studied by Barb and Eli in 2006.[2] They found that patient and physician satisfaction was high. So we stuck with it.

Before we instituted the system, I remember deciding I'd really like to get away for the weekend, but my patient's just 37.5 weeks. So I can hand her over to someone and come back on Sunday feeling remorse and disappointment that she had delivered. When it's my obstetrics month now, I'm in town. I don't drink a glass of wine with meals; I don't go to the cottage. I just know it's my month. I'm here. Knowing that is a great energy saver and I haven't missed a delivery since. I haven't had that sense of disappointment when you're planning to attend a delivery and you end up not being available at the time she delivers.

A stable, satisfied, not-burned-out physician group

Having a stable, satisfied, not-burned-out physician group goes a long way to providing a continuous obstetrics program. I'm convinced philosophically that this is providing patients excellent service. At the beginning, I had a couple of patients come to me and say, "I don't

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Marathon family physicians (from left to right) Barb Zelek, Nancy Fitch, Sarah Newbery, and Eli Orrantia

want to choose another physician. I want you. You were involved in my first delivery, I want you to deliver my second baby." That continues to happen. Emotionally, that is a hurdle to overcome.

We screen women early in their pregnancy for the status of "low risk." Women who are determined not to be "low risk"—I don't want to say "high risk"—are informed that it's recommended that they deliver in Thunder Bay or Sault Ste Marie or some other tertiary care centre of their choice, with consultation from an obstetrician, or a family doctor or midwifery group that practises in a tertiary care setting. We have an obstetrics program package that goes out at their first prenatal visit, basically explaining what "low risk" means, what it means to deliver at Marathon hospital [Wilson Memorial], what services will be provided and what services won't be provided. We ask them to read that and then confirm that they understand it. I consistently encourage women to discuss the matter carefully with their husband or partner. Often they come to their antenatal visits themselves and it's not okay for me to hear them say, "I want to deliver in Marathon." I want to hear them say, "We want to deliver in Marathon."

We encourage women to come and visit the hospital and get a feeling for the room. The environment here in Wilson Memorial, to me, is very good. There is no house in town that it takes longer than 5 minutes to get to the hospital from, so distance is no issue. The room is large, there's a whirlpool tub, it's quiet and separate from the goings-on that may be happening in the emergency department. I feel that the labour and delivery room is an excellent environment.

If a woman chooses to deliver in a tertiary centre even if they're low risk, that's mostly around the small risk that something goes badly, for the cesarean section. The number-two reason, in my experience, is wanting the epidural. Marathon hasn't provided an epidural service, and it's so common that many women feel that they want access to that. I completely understand that. Women who would prefer to deliver at home, I have to explain that based on risk, without using the terms "risk management": already you're choosing to deliver 300 kilometres from a tertiary centre. I encourage them to minimize risk just a little more by at least being in a congenial hospital setting. I have offered several women to come to their home and do a cervix check. I've created that experience for women who are very clear in their goal for staying home as long as possible. Once it's established that they're dilating I encourage them to come to hospital. That's when we can do fetal heart rate check and have the one-to-one nursing relationship initiated. I feel that helps things later.

Risk management: it's a hot topic. I feel that women will get different speeches from different obstetrics care providers around the concept of risk—hopefully the same content, but possibly in a different order. Does that influence some women in one way and some women in another way? Absolutely. That's the nature of physicians being human beings.

We're about helping individuals understand their statistical risk and be clear on their options to minimize it, yet the art of medicine is supporting patients to manage the inevitable risk, and have positivity and confidence as they approach that inevitable risk. You'd probably get a different answer from somebody who approaches obstetrics more from the science brain and not the art brain. I believe in the power of women in childbirth. That positive focus is very strong for me and my first bias is supporting women to understand that they are powerful and capable. I chase that with the conversation of the risk. I think some other physicians will make sure that they understand the risk and then support them in that decision by promoting their confidence. Am I confident that women understand the risk? I feel confident that a conversation about risk is happening, I can guarantee that.

It's not just words; we're in it together

There have been lots of hairy times. I'd say the times that I ask myself, "Why are we doing this?" are consistently the times that I feel so exhausted that I fear not being able to make excellent clinical decisions. It's not actually about craving a cesarean section down the hall. Every time I've reached that place where my exhaustion may be impairing my ability, I've been able to ask for help. Any group where people lean on each other for shared service provision—obstetrics, emergency services—has to have respect for each other's skills. I feel so confident in my colleagues' skills. I remember one time I asked for help on a decision around a patient who had been fully dilated and pushing for 2 hours. I just remember kind of sinking to the floor in the doctor's lounge and just saying, "I'm so tired." [Another local doctor] very gently said, "Do you feel able to continue?" I think 20 other times I would say, "Yes I can," but that time I said, "Maybe not." [The other doctor] went in and took over because I couldn't continue. I was still present but I didn't have to be making clinical decisions any more. I'm so thankful for that. In my recollection, 100% of the times that I have had to ask for help, I have received it. So even then I'm not wishing to be in a different centre.

I try to determine antenatally and into the first stage of labour any signs of possible fetal compromise. The sooner I can identify that, the better for optimal management of that unexpected difficulty. We may be transferring them for the obvious need for an epidural, or for inappropriate fetal lie. She may not go to cesarean section—but she may—so the sooner you act the better the outcome will be. We guarantee that the obstetrical

providers are keeping their certifications up. We have a mandatory consultation policy for induction of labour, another physician to make sure we're minimizing the chances of a difficult induction. In our setting without pediatrician or obstetrician backup, we promise 2 doctors at every delivery, since there are 2 patients. I can get someone for a second opinion at any point. There're not many other occasions in medicine where you get to do that. I'm able to observe and support a colleague in a delivery, learn from them, and celebrate their effectiveness, their capacity. I think that builds a genuine respect. When that's not there, it's much more unsettling to run an obstetrics program.

We guarantee one-to-one nursing support because of the evidence that it improves labour outcomes. You spend enough time with your nursing colleagues to have a deep respect for their contribution and their skills. From conversations with the people who reinstituted the obstetrics program, the biggest challenge was nursing comfort. Nurses who hadn't had a delivery in some time or hadn't been a labour attendant for several years were all of a sudden expected to be back providing one-to-one care. The physician group has been diligent about addressing that RN comfort and confidence issue, and putting on RN education sessions. The feeling that the responsibility is shared naturally among the team is a very real experience. It's not just words; we're in it together.

I've delivered colleagues. There's no doubt that there's more emotion in the experience. I trust my hands and brain to be functioning well in situations where the emotion is more intense, if I'm frightened or overexcited. I find that I can rest my confidence in the innate skills, from just being dedicated to practising obstetrics over time. One physician colleague I delivered had a tiny vaginal trickle that wouldn't stop after delivery. It was such a small trickle. I think in other situations I would have left the room and reinforced with the nurse that uterus massage was to take place and she could call me if the trickle didn't stop. But I couldn't leave it, so I was using a speculum and I saw this tiny fresh trickle of blood coming from the cervix and I thought maybe there's a cervix tear. Doing that caused pain, you know, having a speculum post-delivery and going all the way around the edge of the cervix. On reflection, it was normal. I think I left the room and there was no further work for the nurse. There's documentation of this in the medical literature, about physicians and nurses having different care. I'm aware of that, but I have confidence in the service providers and being able to ask for help plays into it being okay to deliver friends and colleagues.

I've been in Marathon 8 years. One time, some point around year 4, [my colleague] Eli took me by the shoulders, he just looked me straight in the eyes and said, "So, Nan, have you killed anyone yet?"

I was completely shocked by his question. I frowned and said, "No! Not to my knowledge."

And he said, "Well, you will, so get used to it." And then he walked away.

I don't know where it came from. I don't know what was going on in his mind. But it really helped me wrestle with that possibility, the very real possibility, that I might make a tragic mistake. I'm aware that doctors are human and have the capacity for making mistakes and that a personal mistake of mine may have a horrible impact on some other person's life. I feel that going into an obstetrics month, for sure. I feel the possibility of a tragic outcome just hovering. And definitely as my obstetrics month approaches, I do review in my head. I remind myself of the naturalness of pregnancy and labour and the power and capacity of women, to counter the anxiety of being an obstetrics provider 300 kilometres from a C-section. When you have patients approaching term, you know there's going to be some disruption to the way your life works, and it's partly that: the unknown. When am I going to be called? Am I going to have to cancel clinics? Am I going to be in a situation that's difficult to manage—a situation that's impossible to manage and have a good outcome? I accept living with that risk. I feel that I've been well trained. Humanity isn't machines, you know. It's all messy and that's all right with me.

Dr Orkin is Assistant Professor at the Northern Ontario School of Medicine in Thunder Bay, Ont, and a resident in Public Health and Preventive Medicine at the University of Toronto in Ontario. **Dr Newbery** is Associate Professor at the Northern Ontario School of Medicine and a family physician practising in Marathon, Ont.

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Competing interests

None declared

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