

Rupa Patel: "We straddle those worlds"

Narrative 10 of the Marathon Maternity Oral History Project

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In 2008, we interviewed women about their experiences of childbirth and maternity care in Marathon, a rural community in north-western 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

My name is Rupa Patel. I have a story as someone who gave birth. I have a story as someone who attended many births. That was in 1996 to 1999. Three years.

There was a bunch of us who moved to town and we started looking into what we needed to do. Three couples, and we were all family doctors. We worked a lot those first few years, updating or initiating protocols, training the nursing staff. They had an obstetrical program, although it had stopped for a number of years. Many women were traveling out of town. They don't know who you are. If you see a stranger walk in the door, you are half-naked and in pain, that's scary. But if you're seeing someone that you've gotten to know and trust, that's the ultimate relaxation. The physician and the woman, that relationship is central to birth. Maintaining the same provider is actually ideal. It was our gold standard. I don't think that can happen all the time, but to have that service available is actually community building.

At that time, we didn't know that rural obstetrics actually has good outcomes. Now, it's pretty clear. The evidence is there. There is some risk assessment initially that you can do. Women get transferred, but the stats are good. There was a discussion about risk; we had a consent form. "These are your choices. As someone who lives in Marathon, you can choose to deliver here where there is a slightly higher risk because there's not the immediate availability of a surgeon, or we can set you up to see someone in Thunder Bay and you can go back and forth and hopefully get there when your labour starts."

I think pretty well everyone decided to have their baby in Marathon. They had some faith in us. In a small community, you get to know people in about 2 days, then it's all around town. You kind of know if they're a goof or reasonable people. So we were reasonable people. That was the word on the street. There had been a few births that had gone well and gently. Slowly, one birth at a time, it just sort of happened, and it was great. Trust was earned, plus the births sort of won people over.

Giving birth in a place where you work

My oldest, Kahvi, was born in Marathon. As a physician in town, delivering in Marathon was a pretty powerful, important message, a very symbolic thing for the community too, that we were having babies there. Nurses or doctors always have the most horrible complicated things; something always seems to go wrong with your pregnancy. My baby stopped growing at 28 weeks. My symphysis fundal height just didn't grow. So there were issues about intrauterine growth retardation, about whether I would deliver in Thunder Bay, if the baby was IUGR, I would have to be somewhere there was a pediatrician.

Anyway, we decided that he wasn't IUGR. When you do an IUGR assessment, you need an ultrasound every 2 weeks and then there's a parameter of growth that the baby has to meet. So, we're having the ultrasound in Marathon, to be sent to the obstetrician in Thunder Bay. He's just a little dot on the machine. You just click and click and it was, like, small.

We were like, "Do that again."

So she clicked again and it was borderline. "Do it again."

So she'd click again. We kind of made her decide it was okay. It was bizarre, like within a millimetre or two of the line. You can actually change your measurements quite dramatically. It's a very fuzzy little creature. So there was a bit of manipulation to avoid the IUGR diagnosis and just say he's a small baby. By the strict definition, maybe he was IUGR.

So then my water broke. I ended up having to have prostaglandin because I didn't go into labour. I think I had tetanic contractions, actually. They were 1 minute long and it was, like, a 5-hour labour.

I went over to Sarah's[†] house because I wanted her to check me there. That's the thing about giving birth in a place where you work. You know everyone and you're

*Interviewed in Toronto, Ont.

[†]Sarah Newbery, co-author of the study.

vulnerable. I was uncomfortable, going to the hospital because I didn't want to be half-naked in a place where I worked. So, I went to Sarah's house. She has this big tub and she would check me there, and finally I was 7 or 8 centimetres and I went to the hospital. The nitrous was very helpful because it was actually quite painful. Then I was 9 centimetres and the baby's heart rate dropped to 70. It was a prolonged bradycardia for about 3 minutes and there was a bit of panic.

I don't know what happened, but it recovered and it must have been okay. It must have just been the cord that kinked or something, I don't know, but he was fine. Then there was the pushing for 2¼ hours. Then I gave birth.

Hard to be a labour coach

When Sarah was pregnant it was very exciting. It's a more emotional experience having someone you really love be in your care as a physician, to watch someone you love in pain. I had a whole lot more empathy for dads and partners. There's that part of you that just feels helpless and stressed that your loved one is in pain. It's upsetting. I don't know that I had a good sense of that: we expect dads to be the labour coach. It's hard to be a labour coach when your loved one is desperate. They can't be the labour coach!

Sarah just called and said, "I think I'm going into labour." I went over to her house again. I think she just felt like not going to the hospital too early. Finally we decided to go to the hospital, I'm not sure exactly why, because we could bring the fetal monitor to her house and stuff. It was a long labour, and I think at one point she was really tired because she had been up that whole night, and maybe the night before. At one point she was kind of losing it and she's going, "I think my pelvis is going to break apart!"

I'm not sure I would have felt that emotionally involved had it been a more distant colleague, but because I was really close to Sarah, you become sort of crazy. You're so stressed for the person, thinking, Why is she saying her pelvis is going to break apart? It can't, can it? I was just empathizing a bit too much. I phoned my husband, Mike, who was at home: "Oh my God, she's in so much pain, maybe her pelvis *can* break?"

Mike came in and it was like a breath of fresh air for all of us. He got her moving around, changing positions, got her something to drink. Finally, she got stuck at 9½ centimetres, and we started oxytocin. With experience, I would have done this much earlier. I know that now. Just needed a little kick to move that cervix, and



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then she did the pushing. She had her baby and he was something like 9 pounds. A giant!

Then, like classic post-birth, Sarah is all happy and we're all exhausted and drained. We wanted to die, and she's got all this adrenaline going. It was all so nice and beautiful and it was kind of fun. The four of us were there. We had gone up there to Marathon together. Eli, Sarah's husband, was there when Kahvi was born, so the four of us were there at that time too. It ended up that we had called each other's partners in, so it was kinda cool.

When things go well in obstetrics, they're progressing smoothly, and you don't really need a doctor there. In Marathon, if anything's funny or the baby's not responding properly, you're like, "You know what, something's not right. We're gonna have to send you to Thunder Bay." People were okay with that. They know there's a limitation to what's available in Marathon. The medical helicopter would come every three, four days for something—not just for birth. That's a reality in a small town like Marathon. In some ways it was easier, except for those very emergent situations.

The buck stopped with us

The one that I think was scary was a woman who had her first baby. It was a long labour. She had come in and out of hospital for false labour for a week, and because we were following our own patients, I was always called when she came in. It was always at night. I'd go see her, then come back home. She and I were both very tired. Finally she got into labour. I know now that it was a dysfunctional labour, a long latent stage and the active part of her labour was not progressing as quickly as it should have. But you know, there wasn't anything obviously wrong that you would decide that she needed to go to Thunder Bay. So we did the active management stuff—we were big on the active management stuff, the oxytocin. So things moved along, and it was just long in the night, and finally she became fully dilated.

I didn't pick up that she was OP, occiput posterior. That was my miss. She was pushing and pushing and things weren't progressing. Then I did a vacuum. We always had a second person at that point. In a teaching centre, doing a vacuum without an epidural would be horrible to some people. We tried a pudendal block as well, and then we did vacuum. So then the baby was finally born, and it was OP and I did a vacuum. It was like, "Shoot, I should have known that!" You can still stick a vacuum on an OP babe, but it's not great. I know obstetricians who have stuck vacuums on OP babies. I did get Sarah to check—when we did a vacuum, we'd get the other doc to check. We'd confirm position. Both of us were wrong that time. Then she delivered, the shoulders came out fine, that was good, and then the placenta ... so the baby was good, big. Everyone was happy.

Then the placenta doesn't deliver. I don't know if I tugged too hard, because I have seen that since. The cord just came and she started bleeding. Anyway, she starts bleeding, bleeding, and Sarah, thankfully, just took over because I think she could tell I was distraught. I think I would have managed had she not been there, but she just took over, did a manual removal, delivered the placenta. Things worked out. The next day, she was so happy. She thought everything was fine. She had her baby and she got to deliver with her family in town.

I felt bad. I thought this wasn't humane. Is "humane" the right word? It was just so painful for this poor young woman. What could I and should I have done differently? A bit of beating myself up. In family medicine often there's someone else who has more expertise, but there wasn't that person, so the buck stopped with us. I think most rural docs feel some of that. There's no one else to defer to. We feel like we have to control and manage everything. You can't actually. Now that time has gone by, I feel like I have more forgiveness for that sort of thing, but at the time, I felt responsible. We were the people in charge of it, so we should have been able to figure out if she was OP. I mean, come on!

Thinking things through together

There are doctors who don't provide obstetrics in small towns because of that. In the 3 years that we were there, I didn't feel like anything happened during the labour where it would have made a difference had we been elsewhere. Maybe we were lucky—people say that I've been lucky. We have women who come in who have aborted and the baby died. Perhaps if they had been in Thunder Bay the baby might have been saved, but those sort of catastrophic things can happen anywhere.

But I also feel like there's a strength in the relationship. People know that you do the best that you can, and are accepting of outcomes if they know you've done the best that you can. You're actually thinking things through together and figuring things out. You can't always do that, but most of the time you can. There's this empowerment in birth unlike any other physical experience. It's like people who run a marathon. They feel good about themselves, they have that spark inside them. I think that some young moms, who don't have a lot of power in their lives, feel so good about themselves when they've gone through something that intense and managed it. It's huge.

Maybe I romanticize the empowerment that comes from birth. There's this culture of fear that propagates in obstetrics. I've worked in that culture, rationalized a 30% C-section rate, the medicalization, the epidurals, the monitoring, laying women on their back the entire labour. There're all sorts of stories of crash sections: "You know, they saved the baby. You need to have immediate availability of surgeons because so

much can go wrong so quickly.” There is a very occasional person, although in a high-risk setting, they’ll tell you it happens all the time: “Everyone’s a section until proven otherwise.”

Everyone’s *not* a section until proven otherwise. It’s unfortunate and to the detriment of the woman’s experience. It’s actually very sad for women in general. You can’t really expect patients to understand. It’s a complex issue, not something they’ve thought about. They just wanna have their baby and it’s politicizing something that’s, for them, not political.

It’s difficult to change the dominant thinking when you’re in a setting where people just go with the flow, which is what doctors do—and I think what family medicine does more than anyone. We’ve always had this crutch that family doctors don’t know as much as every-

one else, so then we can’t have strong opinions. Family medicine is perfectly situated to be a leader in maternity care, medicine and society, and issues around the empowerment of women. We straddle those worlds. 🍁

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None declared

Reference

1. Orkin A, Newbery S. The Marathon Maternity Oral History Project. Exploring rural birthing through narrative methods. *Can Fam Physician* 2014;60:58-64. Available from: www.cfp.ca/content/60/1/58.full.

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