



Painting the landscape of rural medicine

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Starting my rural medical career was like facing a blank canvas. In rural medicine especially, we mix art and science, and I had learned many brushstrokes and colour theories during my training; now it was time to paint the scene. Since then, in my 15 years as a GP surgeon in solo practice in Lillooet, BC, I have had many experiences that have forced an artful approach to medicine.

Medical school in Newfoundland prepared me well for working with square pegs and round holes. "Patients will tell you the diagnosis, if you let them," a preceptor told me, "much more so than textbooks." This brushstroke is one of the greatest gifts I received from training—and fundamental to the mixing of art and science.

Not all techniques are learned in conventional ways, and sometimes experiences come with a personal price. My introduction to quaternary medicine occurred when I was 27 weeks' pregnant with my second set of natural twins at the age of 42. Ten years earlier, pregnancy with my first, monochorionic set had been plagued with antenatal complications and delivery at 28 weeks. The babies were 450 g and 700 g—the smallest in the neonatal intensive care unit (NICU), where they spent 4 months. This is not a journey I would recommend.

This time around, I myself became the square peg. Shortened cervix, positive fetal fibronectin, hind-water leak, irritable uterus, footling breech: all were enough for me to insist on staying in a quaternary centre. Indeed, why do tests if we are not going to be guided by their results? However, it seems that in quaternary centres, square pegs fit no holes, and I was sent home. The patient's theory had fallen on deaf ears ... until my membranes completely ruptured. The following days were full of blood tests, ultrasounds, and throngs of doctors, nurses, and fellows—continuous until the most important moment came, when, ironically, I was alone.

Fumbling for the call bell while in the left lateral decubitus position and with one's hands full keeping the baby's feet from falling through the cervix is not easy, and at that time it was certainly not a skill on my resumé. Moments earlier, there had been 5 professionals in the room, including my one-on-one nurse. I was the watched kettle waiting to boil. I decide to yell.

I hear the roll of chairs, then a stampede toward my door. "The baby's feet are hanging out." The words reverberate inside my head with the truth that I wish were just a bad dream.

The minutes that follow change the scene dramatically. My partner, who had gone out for "just a minute," walks into the operating room and sees me on the table;

there is blood on the wall—an unfamiliar brushstroke—and blue surgical drapes are scattered like clothes in a teenager's room. I have no veins left; the anesthetist is pale. I apologize; the timing of my eating lunch was unfortunate. "You have 4 other children," the anesthetist states. "We will have to do a spinal. It might only work on 1 side." Relinquishing my hold on the baby's feet to a third party, I dare to breathe.

The anesthetist is correct; I can feel them start the C-section. My partner holds my hand. The surgeon stops. "Please go on," I say. "I'm okay." Mothers do anything for their children, right?

"You are a heroic woman," the anesthetist whispers.

The first baby's cry hauls me back to reality. A few tears fall but I hold back the river. My partner and I share what we can of our moment of parenthood before the boys are whisked away and the room quiets.

I survey the scene. The surgical drapes barely on; the blood splattered on the wall; the anesthetist with a little more colour now; the team silently working away.

I take this moment to close my eyes. The second set of premature twins has again placed me at the NICU door with no choice but to enter. Vignettes from 10 years ago—the intravenous lines, the ventilators, the repeated tests and silent cries through the endotracheal tubes, pumping, breastfeeding—the images and feelings of my first experiences with motherhood engulf me. The gravity of the future, the NICU and all of its ramifications, again seems overwhelming. I breathe it away and grasp at the present: *I'm a mother now; my doctor coat will sit in the closet.* I will follow the green paint line on the floor to the NICU every day and night for many weeks before taking my family home.

Months later, I deliver the first baby born by C-section at my community hospital since my twins' delivery. As I reach to disengage the head, images of the NICU flicker in my mind. Not every brushstroke is one we envisioned but each adds to the beauty and complexity of the finished work. With every patient—even when that patient is me—my understanding deepens. The artful practice of rural medicine is a work in progress, and I take solace in knowing I will mix art and science, listen to and hear this and each child and family in the context of their own culture and surroundings, for decades to come. 🌿

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Competing interests
None declared