Second-Guessed

Category: Stories
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It was a good night, but it's been a brutal morning.

As a family doctor who does obstetrics, I generally enjoy my time with laboring patients. When I arrived on the maternity floor last night to start my call, things looked pleasantly uneventful. Several patients were in labor. Only one wasn't progressing well: Ana, age twenty-two.

I was told that Ana had come to the floor two days earlier, leaking puddles of clear fluid but not contracting. She still wasn't contracting, even after two days on pitocin, the drug that causes or strengthens uterine contractions.

To add to this difficulty, there was Ana's shift nurse, Barbara.

Barbara and I had a history. Another night, caring for a very annoying patient, I'd thought that Barbara had acted unprofessionally, and she'd accused me of shirking my responsibilities. We hadn't parted on the best of terms.

As the night wore on, Ana's uterus finally began to contract, but she didn't tolerate the discomfort well. She was also fearful of taking any pain medication—a perfect catch-22.

Avoiding a replay of our last collaboration, Barbara and I managed to soothe Ana and her husband, and they changed their minds about Ana's getting an epidural.

Now pain-free, Ana got a steady dose of pitocin all night long. And I got a four-and-a-half-hour block of sleep—a luxury on OB call.

The next morning, Barbara woke me before 6:00.

"Can you check Ana?" she asked. "If she hasn't made any progress, can we turn off the 'pit' and call it a day?" By this, she meant schedule Ana for the c-section that she'd been promised if her cervix didn't dilate overnight.

Under my gloved fingers, Ana's cervix felt unchanged. The baby's head seemed asynclitic (turned to the side and not well applied to the cervix), which might explain why Ana wasn't dilating well. And I didn't feel any bulging bag of amniotic fluid, which went along with her history of leaking dramatically. The c-section looked more and more certain.

But the obstetricians on call weren't happy with this plan: They had two other c-sections already scheduled.

How sure was I that Ana's water had broken? they asked.

Ninety-plus percent, based on my exam, I said, then related my concerns about the baby's head position.

Dr. Jarvis, the obstetrician coming on for the day, decided to examine Ana herself.

Looking at Ana's fetal monitoring strip, she said, "She's not contracting!"

I explained that we'd turned off the pitocin to give the patient a break. She pointed out, rightly, that with the epidural in place, Ana hadn't been uncomfortable.

I mentally kicked myself.

Mistake number one: Wanting to avoid a confrontation with Barbara, I'd simply agreed when she had suggested turning off the pit. Given Ana's tepid progress, I'd also believed that it wouldn't make much difference.

Reviewing the tracings that recorded Ana's progress, Dr. Jarvis said, "Her contractions haven't been adequate."

I bridled: Ana *had* been uncomfortable; Barbara and I had agreed that her contractions had felt moderate; she'd been contracting for more than twelve hours. And yet….

Mistake number two: Before turning off Ana's pitocin, I should have given her the highest possible dose and asked to be awakened after two hours so that I could check her progress and maybe insert an intra-uterine pressure catheter to measure her contraction strength. But between wanting to minimize the number of exams (which increase the risk of infection in a woman whose sac has ruptured) and feeling that higher doses of pitocin wouldn't help anyway, maybe I'd closed that door too soon. Or maybe I just didn't want to fight with Barbara about it.

Or maybe, if I was to be brutally honest with myself, I just wanted to sleep.

Dr. Jarvis checked Ana. "I feel a bag. She's not ruptured. Hook, please."

I handed her an amniotomy hook. Clear fluid came running out.

To complete my humiliation, Dr. Jarvis said, "And she's not asynclitic; she's left occiput anterior"—a perfectly normal position for the baby's head.

Mistakes three and four. Missed the sac. Got the head position wrong.

Part of being a family doctor who does obstetrics is being second-guessed by the specialists—the ob-gyns whom you consult when you have concerns or need a surgical intervention. Often your judgment is found wanting.

This can be tormenting, because in obstetrics, as in all of medicine, you can do the right thing and have a bad outcome. Or you can do the wrong thing and

have everything turn out well. Also, the lack of scientific evidence for many protocols used in childbirth, and the potential for catastrophic outcomes, makes everyone's emotions run high. In this high-stakes situation, specialists tend to support their opinions with a nonscientific phrase: "In my experience." It's unanswerable because, as the specialists, they do have the most experience.

I walked into the staff room to find my morning replacement there with some nurses. When I described what had happened, they told me not to take it personally. Dr. Jarvis was known for her brusqueness, and it had been reasonable for me to turn off the pitocin.

Mulling it all over in the light of day, I'd like to believe that they were right—but I feel at least partially culpable. And as the night's events go round and round in my head, there's what I come up with:

*I tried to help Ana deliver vaginally, but because I was pessimistic about her chances, I didn't push hard to give her every chance.

*We minimized the number of exams to lower the risk of infection.

*I didn't want to fight with Barbara.

* When Barbara expressed discomfort with giving Ana a high dose of pitocin, I didn't think it would make a difference, so I went along.

*I was asleep at 2 am and happy to remain so, knowing that the following evening I'd be the sole caregiver for my very active toddler.

*Finally, when I examined Ana's cervix at 6 am, maybe I didn't check as thoroughly as I should have.

It's possible that my exam isn't as proficient as I'd like to think. (One study shows that obstetricians, using vaginal exams, get the baby's position right just 50 percent of the time—so maybe no one is all that good.) But it's just as possible that something changed during the two hours between my exam and Dr. Jarvis's. Maybe the baby's head shifted and the amniotic bag became more apparent.

There's no way to know.

Perhaps I'd feel some vindication if Ana needed a c-section after all, but the last I heard, she was contracting well and headed for a vaginal delivery.

All that I can do is to ask what I might have done better—then try and do it. Next time, which will be next week, I want to stay more aware of my potential biases and try to sidestep or blast through them. Dr. Jarvis may have been arrogant, but that doesn't let me off the hook.

So it may have been a good night, but it's been a hell of a morning.

About the author:

Andrea Gordon is on the faculty of the Tufts Family Medicine Residency Program at Cambridge Health Alliance in Malden, Massachusetts. “Although I wrote poetry in high school, I had stopped until my advisor in residency told me, ‘You should write poetry.’ That was enough to start me writing again. I feel privileged to be invited into people’s lives and to hear their stories.”

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