*Written over time,
read at our writers' group,
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Miracle

By Vicky Van Dyke, CNM

"Do you have privileges at the hospital yet?" I looked up from my computer charting to see my colleague, Julie, standing in the doorway. "Yeah, I was on call last weekend, why?" "Well, I'm supposed to be on call tonight and I just found out that the medical staff office didn't finish processing mine. Now it's past five o'clock and it can't get done today." The impact of what she was saying hit me—we had to have someone available for the laboring women who would surely be arriving at the hospital all night. Our obstetric group had just moved from a hospital that closed to a new facility. All of the members of our group were experienced, competent practitioners but all hospitals have a checklist of information that has to be completed before they allow a practitioner to care for patients. Only a few members of our 11-person group had gotten through the process.

I thought through the reasons I might not be able to do it. Tired from a long day at the office didn't count in this situation. No previous engagements for the evening. No young children at home requiring care. I hadn't been on call the night before. I didn't even have the excuse that too many patients would have to be moved from my next day's schedule—I was scheduled to do some work for our marketing department and therefore did not have any patients to be rescheduled. I sighed inwardly. "Sure, I can do it. I'll just finish up here and head on over." She looked relieved. "Thanks, I'm not scheduled again for a while, so I should be able to get it straightened out."

As I walked through the door of the hospital, I noticed a large group of people gathered outside the door of one of the rooms, some crying, some looking angry. Further down the hall, a small group of nurses was talking with great animation.

Arriving at the call room, I changed quickly into scrubs and went looking for the people who had been on call that day so they could "sign out"—tell me which patients were ours to care for and what their condition was.

I found my friend and colleague, Kristy, standing with the group of nurses. "You're probably going to be sorry you volunteered for this. You're walking into a powder keg." That could mean anything when you're talking about caring for laboring women. Kristy and I walked own the hall to find a private place to discuss the patients.

"We're not terribly busy," she said, "Only one person in labor, but she's a doozy. She and the family are pretty upset at all of us."

"Why?" I asked.

"Lots of reasons. Have you heard about Camie Bentley?" The name did sound familiar. Then I remembered—the patient screaming at my colleague with the office next to mine a few months ago. Dan had been upset enough about the interaction that he'd talked about it for days after. Apparently he had been discussing a 20-week ultrasound report that showed that Camie's baby had a serious birth defect called ancephaly. This means that most of the brain is absent. Babies with this disorder rarely survive more than a few days after birth and most die within minutes. Carrying a baby destined to die is a burden few women want to shoulder. Dan had started to arrange a termination of the pregnancy, assuming that this was what the patient would want. She had become hysterical. A devout, "born again" Christian, she did not believe in abortion for any reason. The last words I heard her say were, "You don't know everything. Tests can be wrong. They told my cousin her baby would be deformed and he was all right!" With these words she had stormed out of the clinic. Dan and his nurse had contacted her numerous times since, but she refused to come in for any more prenatal care, not wanting to discuss the issue any further. And now she was in labor. I sensed things weren't going well here, either.

Kristy continued. "She came in contracting on her own and has been insisting on having continuous monitoring. We don't want to do that, because we don't want to have to do a crash c-section if we see distress." "That seems sensible—this situation is difficult enough without subjecting the mother to the pain and potential danger of a c-section," I answered. I, too, was mak-

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ing the assumption that the mother's safety should be the primary concern when survival for the baby was impossible. However, when Kristy explained the full nature of the conflict between the woman and her husband and the medical team, it was obvious that what seemed sensible to us was only making the family angry and alienated. Complicating things further, in addition to her family, the patient had her minister and a ten-person prayer support group in the room. None of them were talking to the daytime medical team any more, stating that they did not trust them and they had been waiting for our "change of shift" to have a new person to deal with. Kristy finished up with "That patient's husband is in Holly's office and he wants to talk to you."

I took a deep breath. I consider myself a spiritual rather than a religious person, having difficulty finding any church that "felt right." But I had been raised in a fundamentalist Christian family and know a lot about the common beliefs. I encounter patients whose belief structure impacted their decision making all the time and generally have no difficulty finding a treatment plan that was respectful of their faith and safe for the fetus. This isn't all that common, unfortunately. Many highly trained, scientific medical practitioners find their rationale impossible to understand and try to direct them more. The night promised to be a challenge, but less for me than others in my group. I decided it was good that I was going to be the one here.

I went first to meet with the father of the baby, David. I'm a small woman, and David was only slightly taller than me, slender and muscular, wearing cowboy boots and a big buckle. His dark eyes were flashing and his face flushed.

"Hi, I'm Vicky. I'm the midwife on call tonight. I hear you've been having some troubles. Why don't you tell me what's been going on?"

The story poured out of him. They did not believe that the fetus would be born with the predicted severe life-threatening defect. "We're expecting a miracle. We're expecting God to heal our little girl tonight. That's what we are all praying for and we believe that God answers prayers. So we want her to get the best possible care. We want her to be treated like the healthy, valuable child of God she is and for everything possible to be done to save her. Is that so unreasonable?" He looked exhausted and on the verge of tears as he pleaded with me. I thought about it. As he explained the situation from his perspective, I could see why they were demanding care for their child. We all, instinctively, want to do everything for our children. A mother myself, I could understand that. I told him so.

"Well, you know, David, I agree with you that there will be a miracle here tonight. I'm not sure I believe it will be the same one you are expecting but I do believe that we will experience a miracle. And I want to give you the same care I would any other family in labor. But I do have to let you know, I'm not a fan of continuous monitoring in any situation. Over the years it's been shown to increase the c-section rate without really improving outcomes for babies. I think the labor would go faster and therefore be easier on both your wife and daughter if she was up walking and we listened to the baby's heart rate intermittently. Intermittent monitoring is an accepted obstetric practice."

"What about resuscitating her after she is born?" he asked.

I answered, "That's not as clear cut to me but I'm willing to respect whatever decision you and Camie make. I just want you to have all the facts. Have you ever seen a full neonatal resuscitation before?" He hadn't. "They can be pretty brutal. The baby is whisked away from the parents, a tube is placed down the throat and another into the stomach. An IV is started in the umbilical vein and medicines are given. It is almost always necessary to breathe for the baby with a bag and most need chest compression. I know you believe she will be healed and not need this but what if it turns out God intends a different miracle tonight? Is this how you want to spend the precious few moments you will share of her life?" I could tell he hadn't thought of this. "Would you explain all of this to my wife?" Of course I would. I sensed the tension that I had first felt from him draining away and he seemed calmer and more ready to face the rest of the labor, whatever it brought us.

I entered Camie's room. It was darkened; there was soft music playing and clusters of people with their heads down and their hands clasped were murmuring prayers. A man who was introduced as the minister was standing at the head of the bed, one hand on a Bible and the other on Camie. She was working with the contractions and appeared to be coping well with them. "Camie, I think you should listen to what the midwife has to say," David started.

"Hi, I'm Vicky and I'm coming on to take care of you tonight. David's been telling me about your difficulties today and I'm wondering if you'd like to hear my opinion of what we should do." She looked at David and he nodded. I repeated my belief that continuous monitoring was not necessary to protect the baby. Again, I said I believed there would be a miracle, but I wasn't sure what it would be. There is a miracle at every birth and I wanted her to have the most healing birth possible. She agreed with me and we took the monitors off. She went to sit with her prayer partner, and they began to pray in earnest, with Camie stopping from time to time to breathe through a contraction. I went out to tell her nurse that we would be using the intermittent protocol and that the family was deciding about the level of resuscitation they would want.

I went back into the room, partially for labor support and partially to get a sense of who was there and what their roles would be. The minister and her prayer partner seemed focused on Camie and genuinely involved in supporting her. Her husband seemed loving, and they seemed connected as a couple and trusting of each other. The reactions of the church members varied—some seemed there for moral support, some to watch the show, others mainly seemed there to share every horrible birth story they had ever heard. I see that often with laboring women and I wonder at the cruelty of it.

The night wore on, and Camie made steady labor progress. She refused all pain medication, fearing it would compromise the baby. We talked a lot in those hours about her faith and the experience of the pregnancy. Finally, I broached the subject of resuscitation after the birth. "If she is ancephalic and your moments with her are going to be limited, how do you want us to spend them?" I could see her mother's heart struggle, then answer, "I want her life to be gentle. I want her to feel our loving arms and hear our words. Don't resuscitate any more than drying and suctioning her." I nodded. That felt right to me, too.

The birth of a full term ancephalic presents other complications that we hadn't talked about but were at the back of my mind. Without a full scalp, it is often difficult to distend the mother's tissue enough to have the head come through the birth canal. Women push to exhaustion. The risk of having the shoulders get stuck is higher. I'd never done this before and was a little nervous. My backup MD, at home, hadn't either.

Throughout the evening, there had been a video camera filming parts of the birth. Many of my colleagues don't allow cameras to film deliveries but I usually do. For some people this is an important way to be able to make peace with their birth experience. I was pretty sure that was going to be necessary here.

About midnight, it was time to push. We gathered, me to coach her, the minister to bless her and the congregation to pray for the miracle. She pushed with a strength and determination that I had to think was otherworldly. It took hours. Finally, the head was low enough that I could feel it. It was ancephalic—should I tell them? I decided to. "The head I am feeling is shaped in a way that leads me to believe that your baby will be ancephalic." The praying intensified. Camie's eyes met mine and I could tell she was ready for whatever the next few moments gave her. We sat in a halo of light from the exam light, the rest of the room darkened. The soft sound of hymns around us, I reached in, hooked my fingers around the little arms and pulled the baby forward into the world. Other than the lack of fullness at the back of her head, she was a beautiful little girl. I laid her on her mother's abdomen and she cradled her gently. "Welcome to the world, Hope" she said. I felt the umbilical pulse—life-giving blood continued to flow from her mother but the baby made no effort to breathe. Her eyes were open and she appeared to look at her mother and father. "Camie, if I cut the cord, it will stop the flow of oxygen from you to her and that is what is keeping her alive. It will stop on its own soon, but I want you to have her as long as possible." She nodded and continued to explore her baby. The cord continued to pulse for what seemed to me a very long time, then got weaker and weaker. Hope closed her eyes. Her mother kissed her and I cut the cord.

I looked up at the quiet crowd. They were silent, not knowing what to say or do. Who does? Words came to me. "There was a miracle in this room tonight. The miracle I saw was the amazing power of Love. Thank you for letting me be a part of it." The church members slowly drifted away, leaving Camie, David, Hope, and the minister. I left, too, to give them some privacy. Walking out of the light into the hall, it seemed like I was walking into a different world. ❖