Isaac
Third Place Prose 2006

End of life is always hard, particularly so when it ends at its beginning—with stillbirth and fetal death. When I was a family practice resident I was deeply disturbed when doctors' well-meaning but paternalistic actions deprived the grieving mothers of their own needs in order to make the clinicians themselves more comfortable.

I remember two cases in particular—one young mother, close to term, who had been in a car accident and cried with disbelief as she lay in the delivery room, sonographic evidence confirming no fetal heart beat. Without asking her, she was given IV medication "to calm her down", and she proceeded with the labor and delivery in a state of somnolence. I remember feeling outrage—she had every right to cry, she had lost a child, for goodness sake!! Who were we to rob her of her grieving??

Another case involved a teen, who, for the second pregnancy in a row, was going into premature labor at a mere 19 weeks. Being the resident on call, I examined her first and still recall the awful, sickening sensation of a bulging amniotic sac and feeling tiny feet within, kicking wildly as if they could somehow climb back into the dark, warm safety which was releasing them. Both the neonatologist and the OB attending refused to come in, saying that there was nothing they could do, and that I should be able "to handle it" myself. I, the second year resident did "handle it" as best I could, hopefully with empathy and kindness, though my heart grieved when the young boy a-borning, unable with tiny lungs to even cry, merely voided once, and died in my arms. The teen mother held him in a state of disbelief, uncertain what to do, how to feel, and not out of the woods, yet—oh, no, for the placenta, as often happens, had refused to relinquish its place. Again the OB attending refused to come in—"just sedate her and we'll take her to the OR in the morning." I hoped that practices would change and allow for a more dignified and sympathetic handling of future such situations. Little did I know at the time that twelve years later I would have first-hand patient experience.

It was with great anticipation that I went to my routine sonogram at week 19 of my fourth pregnancy, wondering if we were expecting an Isaac or a Madeline. I was immediately aware of a problem—the placental blood flow seemed only one way, and the technician's face lost its smile. I, of course, went into "mother mode", not MD, and looked with joyful wonder at the little head, perfect little spine—(the folic acid worked), and eagerly anticipated seeing more, when she suddenly stopped, saying, "It's routine to get the doctor to check on the sonograms. I'll get her. It will only be a minute." As a "minute" turned into 25 and then 30, with brief interruptions by the tech to ask, "when did you see your doctor last?", "what office?", my unease grew, but I held my belly protectively and still, yes, STILL, felt movement within.

The radiologist arrived and gently began to move the sonographic wand. Again, the little head, the spine, the chest, which I now could see was inexplicably silent, no movement. She said nothing, but looked at me for a moment. Before she could speak, I helped her out—"There's no blood flow, no heart tones, are there?" "No, there isn't," she said quietly, "I'm so sorry." I was still in disbelief, still certain that I felt the little life moving inside me, there must be some mistake, but I got dressed and prepared to make some necessary calls. I had hospital coverage to

arrange and resident teaching duties to delegate, not to mention breaking the news to my husband.

When Dr Brown, (all names are changed), who was on duty for my OB group, called me later, he was respectful and kind. He stated that the best option was for a D and C and E, which would most likely be scheduled for Thursday, (today was Tuesday), as that was the next time the group had early OR hours. Dr. Johnson, who would be the attending physician that day, was actually at another facility at this very moment doing the same sad procedure. Dr Brown further explained that "the products of conception" could be removed at 7:30 in the morning. I'd recover from anesthesia, and most likely be home by noon, ready to eat something if I wished. (Food was the last thought on my mind). He also wanted me to know that Dr Johnson offered another option. "It sounds like torture, but you deserve to know that you can come in and we could induce labor. We would do it in the delivery suite, but we would put you in a far corner for privacy. You'll have to endure all the usual pain of labor. But don't worry—they'll make sure you have medication for pain and some sedation." I was definitely not sure I wanted "sedation", and asked if an epidural was possible. No, that was generally not done in these situations. Without a moment's hesitation, I opted for the "torture" of labor.

We arrived at an LDRP room exactly at 7 a.m. on Thursday, after two valuable days of emotional working through the anger and guilt. I was out of the way but could still faintly hear the "wumpa, wumpa, wumpa" of a fetal monitor down the hall. Rather than being distressed, I was comforted to know that somewhere new life continued when my own did not. I had a speech rehearsed—"I know it's silly, but I can swear I still feel movement. Please have him check again before we begin." The nurse assented. "And please—they won't dope me up, will they? I want a clear head." No, she said, they would not give me anything I didn't want. Dr. Johnson wanted this to be as natural as possible.

The prostaglandin suppository was many times the dose used to induce a term labor. He warned me that it would be miserable and had lots of side effects—fever, nausea, headache, diarrhea. Anything I needed for comfort I could have, don't be afraid to ask, as it was not going to change the outcome any. He was very sympathetic and respectful of my choice to forgo drugs as much as possible, but he also warned that I might need doses every four hours if things didn't progress. "You never know," he said. "Sometimes these little ones appear quickly, sometimes it takes a while." "Little one", he had said—not "products of conception," not "tissue", but "little one"—my little one. I was grateful.

I did, indeed, suffer every promised side effect, all without the haze of medication during the next several hours of labor and delivery. Afterwards they brought me Isaac, wrapped up in a receiving blanket just like any other newborn. The clinician in me saw the distortion of his occiput, the soft and curved limbs, the erosion of some of the more delicate features from being in the fouled amniotic fluid so long. The mother in me, however, merely wept to think that he might have had distress and pain. I was glad that I had given him my own pain, the only gift I could present him. I gazed on the little broken body, but saw only that he was beautiful. He had broad little shoulders, narrow little hips, and ten perfect fingers and toes. I gently touched him all over—he was so cool and soft and fragile. His spine was indeed perfect, as were his two tiny ears. I touched his lips and noted his brilliant, blue eyes. How handsome he would have grown—

probably a blonde and gentle giant like his father. Softly I sang him his first and only lullaby—"Hush, little Isaac, don't say a word, mama's gonna buy you a mocking bird..." When the song was over I said my last goodbye, and allowed the nurses to take him.

The following morning I left the hospital with a lovely box of mementos that I will cherish forever—Isaac's smudgy little footprints, nameband and photograph. I left, too, with a deeper understanding for patients. My clinical and precepting encounters for follow-up miscarriages now encompass more than just the medical facts and exam. We speak the baby's name, if known. We acknowledge that their unborn life still has meaning to others. We may even share a hug or a tear. And never, even for early miscarriages, do we use the term "products of conception".

As physicians, we need to embrace, not shun, our life experiences, thereby taking better care of our patients as well as ourselves. Empathy is a strength, not a weakness. After all, the doctor/patient relationship is first and foremost a relationship between two human beings

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