Teddy

THE THIRD YEAR OF MEDICAL SCHOOL, THE FIRST OF THE clinical years on the road to becoming a physician, left an indelible imprint on me. I will always remember playing chase with the exuberant 5-year-old boy who had been so traumatized by extensive burns and the loss of his mother in a fire. I can still feel the thick air in the room where I listened to a pediatric neurologist review in mind-numbing detail the MRI that served as his basis to declare that a precious 2-year-old girl, healthy only two weeks ago, had irreversible brain damage from fulminant hepatic encephalopathy. These human tragedies moved me, but I often found myself at a loss: What, if anything, could I do to comfort these patients and their families? What must it feel like? And then, during my family medicine clerkship, the last month of my third year of medical school, I understood.

Each well-child check and newborn physical examination carried special importance as I felt my own son kicking inside me. I was counting the weeks until his birth, often daydreaming what he would be like when we finally got to meet him. The ultrasound had revealed a perfect form. Curled-up legs, fisted hands—truly a miracle. But today was different. I hadn't felt the baby move for hours. Daydreams transformed into nagging anxiety, then into an aching pit in my stomach. With Doppler in hand, I snuck into an examination room, determined to find his heartbeat and put my mind at ease. All I heard was my own quickening abdominal pulse. Finally I pleaded with my preceptor to please help me. He listened for the baby's heartbeat, couldn't find it, and calmly led me by the hand down the hall to the obstetrics clinic.

The ultrasound screen was black, silent, cold. Horror filled my heart and every inch of my being. One lonely tear rolled down my cheek. He wasn't moving. His heart had stopped. "I'm so, so sorry," my preceptor said.

So this is what it feels like. Did the mom I talked to on my pediatrics rotation feel a similar horror when she learned that her son and daughter both have cystic fibrosis and that without major breakthroughs she would likely outlive them? How about the woman who heard her husband screaming in the hallway as his heart was urgently transcutaneously paced to keep him alive? What about the mother who sobbed uncontrollably when she knew her daughter would not wake up? As only a third-year medical student so early in my training, I had already witnessed much suffering and grief. We are taught that there is an art beyond the science to giving bad news.

And now, as a patient, I was receiving it. The next days remain vivid in my mind. My preceptor and course director took care of me so that I would not be alone as my parents and in-laws scrambled to journey from Chicago to North Carolina. My husband, an officer in the Marine Corps and stationed nearly 3000 miles away, got on the next flight from San Diego to be with me when we delivered our son.

Stillbirth affects nearly 1% of all pregnancies in the United States. Up to 50% of the time it's unclear what causes the fetal demise. Well-known factors such as maternal smoking, congenital abnormalities, maternal lupus, and preeclampsia increase risk.[1] But I had no history of any problems; I was by-the-book as much as possible during my pregnancy, and a level-two ultrasound revealed a perfect baby. Why did this happen?

As a patient of my home hospital, I was pampered. My doctor listed me as "Ms Doe" on the L&D board, should any of my classmates currently assigned to labor and delivery see "IUFD" next to my name. The residents I worked with on my obstetrics rotation stopped by my room to offer their condolences and support. I refused catheterization, knowing full well the risks of nosocomial urinary tract infection. Fortunately, the anesthesiologists are skilled at "walking epidurals."

The anesthesiology resident, a familiar face from my surgery clerkship, carefully prepared me. The needle hurt, but not too bad. Before she left, she said, "Congratulations. Are you having a girl or a boy?"

"We're having a boy," I replied. "But he's not alive." Her face went blank. She must not have known what the white card with blue flowers that the nurse posted to my door represented. She mumbled, "Oh," and quickly scurried out of the room.

This was one of my first encounters with the awkwardness and omnipresent hurt that accompanies the loss of a child. People don't know how to respond or what to say. And I certainly don't hold that against anyone because, honestly, I never knew the right words either. What can you say or do to help soothe someone who is suffering so immensely?

My physician found the perfect words. She asked me about him: "What's his name? Tell me about him." She wasn't afraid when I cried. Instead she offered me a tissue, gave me a hug, and I think that, silently, she cried with me. She delivered my baby and told me how beautiful he was. No doubt he had his daddy's long arms and legs.

The worst job for an L&D nurse has to be getting assigned to taking care of women with stillborn babies. But

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my nurses embraced me. It would have been easier for them—physically and emotionally—to avoid my room as much as possible. After all, it wasn't necessary to monitor contractions or fetal well-being. But they didn't. They listened when I wanted to talk about him. And they made sure that when he was born to let us spend a lot of time with him, to take his footprints and handprints, to help arrange his cremation, and to make sure that I was doing okay physically and emotionally. This may just be part of the job description. But as a patient I felt loved and cared for at a time when my heart was in a million pieces. As I look back, I wonder if I was able to show a similar compassion and empathy for the patients I cared for over the past year.

Weeks after losing my baby, I learned what might have been the cause. Like 5% of whites, I'm heterozygous for factor V leiden mutation—a coagulation disorder that increases risk of deep vein thromboses, pulmonary emboli, and sometimes stillbirth and miscarriage.[2] The news was shocking: no one in my family had ever had any of these complications.

We all use defense mechanisms to deal with pain, and mine was intellectualization. I learned all that I could about factor V and risks of future tragedy (if I take enoxaparin, maybe all will be well?) and at the same time I grieved the loss of my son. My efforts to "think" like a physician and "feel" like a patient came into clear focus.

As I move toward becoming a pediatrician, this experience will remind me what it truly means to practice with compassion and empathy. While I may never have the right words to say, I won't run from human suffering or be afraid to talk about it. And I won't ever forget the skilled caretaking that I benefited from as a patient. The people who took care of me during my greatest suffering intuitively knew how to help heal my heart. They started by asking me his name.

My son, his name is Teddy and I love to talk about him.

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A moment's insight is sometimes worth a life's experience.
—Oliver Wendell Holmes (1809-1894)