Annika's First Baby

Shuichi Suetani
5th year Medical Student
Dunedin School of Medicine
University of Otago

Shuichi Suetani is a fifth year medical student at the Dunedin School of Medicine. He graduated from Mt. Maunganui College and has a very keen interest in whatever run he is on at any given week. At the moment, he is interested in Neurology.

Annika wasn't convinced.

"I think I can see two lines. What do you think, Murray?" Her husband looked over the home pregnancy test. "I guess so," he said, shrugging his shoulders. "Let me know when you find out who the father is."

That was almost 7 months ago, and by the time she did the test Annika was already 2 months pregnant. "I've always had an irregular cycle, and I was under a bit of stress around that time with my new job and other things," she would tell me later. "But we'd been married for about 6 months by that stage and we were as ready as we were ever going to be."

Fast forward 30 weeks and at least 20 kilograms later, (she was too scared to actually weigh herself) Annika was sitting in front of me at Muffin Break sipping on a banana milkshake. Her usually slim figure had definitely gained a healthy pregnant bump. She wobbled around in the characteristic pregnant way and she took a deep breath every now and then as if she was giving surges of oxygen to her unborn baby.

We sipped on our milkshakes for an hour and a half, going over the questions in my course booklet.

"I always feel so rude asking these questions," I told Annika, "questions about your sex life and your income."

She just shrugged her shoulders and said that it was my job to do so and she was happy to answer them. "You have to learn somehow. I'm just doing my bit to educate future doctors."

Fast forward another 2 weeks and I was running up to Queen Mary, the Dunedin maternity ward. It was Annika's due date and I had just got a phone call from Liz, her midwife, asking me where the hell I was. I sprinted to room 5 and there they were: Annika with her stomach twice as big as the week before, and Murray sitting next to her holding her hand.

"You are a little late," Murray said, giving me his trademark cheeky grin, "you'd better record it in your booklet!" Before I could open my mouth to defend myself, Liz walked in and started asking Annika questions. How is the pain now, how frequent are the contractions, how do they feel, what did you have for breakfast: on and on she went. Murray and I looked at each other, feeling lost in the midst of female jargon.

"Well, it sounds like we've got a bit more to go, gentlemen," Liz announced. "You two can go away for a couple of hours if you want, while I get Annika nice and comfortable in a warm bath."

Two hours later and after an early lunch, I was back in room 5 reading a thick Stephen King novel. Liz came in and out a few times and told me that Annika was still in the bath preparing for the battle ahead. Murray came back and dropped a bag on the couch, went out and escorted his wife back to the room. Annika was now dressed in an XXL t-shirt she got from an op shop and nothing else. She took each step carefully and slowly. Liz asked Annika how she would like to lie on the bed, and Annika replied with some vague noise. The pain was visible on her face.

For the next 4 hours or so I managed to read nearly 100 pages of my book. During that time, Annika was lying on the bed, then kneeling on it and then she went to the toilet and stayed there for a while. Liz measured Annika's vaginal dilatation, brought in an oxygen pump, hot towels, and cold cloths and by then Annika was back on the bed. Murray paced around the room getting out of Liz' way, holding Annika's hand occasionally and going out every 2 hours to feed the parking meter.

Finally, just past 5 o'clock, Liz took her rubber gloves off her hands and announced to the two males in the room, "I think we are ready to push now."

Labour pain is very difficult to understand for a male. Annika tried to explain it to us - "It's like…not sharp…but sharp…diffusing…terrible…pain…all over…all over." Liz, with her vast experience as a mother and a midwife, put it rather more simply; "It's like putting a tourniquet around your testicles, tying it very tight and then slowly taking it off after 20 minutes." Ouch.

I was standing by the bed, holding Annika's leg every time she had a contraction. Liz was standing opposite me doing the same thing and telling her to push, push and push. Murray was sitting by his wife's hand, putting a cold cloth on her forehead when she asked him to. We'd been like that for nearly 2 hours, and we could see the head of the baby stuck in Annika's vagina. The pushing continued and Liz was shouting, "push, push, push!" Annika had her eyes tightly closed. Murray was squeezing her hand. "Come on, Annika, one more push!"

And just like that, the head popped out first, and then the body flew out. I looked at my watch: 19.14. "It's a boy," Annika whispered in her shattered physical state. "It's a boy." Murray could hardly contain his emotions. "It's a boy, it's a boy, it's a boy!"

Oscar James is his name. Little Oscar began crying as soon as he was in his mother's arms. He was red with blood, white with mucus and the world was cold and too bright for him. Liz mumbled something about the baby being healthy and good looking. I stumbled back to the chair and took a deep breath. It felt unreal. Then I remembered.

I was 12 when my sister was born. Dad came home with some fish and chips and told me and my little brother that we had a baby sister. He then picked up the phone and started dialling numbers before unwrapping the dinner. "It's a baby girl!" Dad said again and again to the phone. Different numbers, different friends, but the same line. "It's a baby girl!" After a while, he started crying. "It's a baby girl!" We just stared at our father, the balding middle age man bawling his eyes out and repeating the same line like a scratched CD. We forgot about the fish and chips for a while then.

Oscar James was struggling to find his mother's nipple to suckle on. His little arms and legs waved uncontrollably on Annika's chest. Murray was taking photos. Liz was doing more paper work, recording the arrival of this new life. I got up and shook Murray's hand. I said thank you to Annika for letting me be there and she thanked me for being there. I waved a little good bye to Oscar James and thanked Liz on the way out. "You've been a big help." Liz gave me a little wink.

As I walked out of Queen Mary, I looked at my watch and wondered if the Flying Squid was still open at this time of the night.

To treat, or not to treat?

J. Charmaine Chan
Trainee Intern
Christchurch School of Medicine
University of Otago

Charmaine is a trainee intern in Christchurch who wrote this as a fourth year. Unfortunately she is prone to procrastinating, hence never got round to editing her article.

Miss F was the sprightliest 100 year-old I had ever met in my life. In fact she was the only centenarian I'd ever met. She was recovering from a hernia operation at Princess Margaret Hospital, Christchurch. The first time I met her was during the consultant ward round. Her opening sentence was, "I've had enough, I want to die". When told that this was something she would have to tell The One up there, she replied that she was in the process of negotiating. She repeated this desire the following week during ward round again, and clearly stated that she did not want to be treated for any illness she might develop while on the ward.

The following week Miss F. developed pneumonia. She was febrile, confused and rapidly deteriorating.

'Would you like to be treated for your pneumonia?' the medical team asked.

'I don't know, I don't know…', she replied.

'We can treat your pneumonia, or we can offer you supportive care, and make you comfortable. You said last week that you didn't want to be treated for anything.'

'Yes.'

'How about now?'

'I don't know, you decide…'

Herein lies one of the most unpleasant decisions the clinician has to make. When should one withhold treatment?

In this instance it was crucial to assess Miss F's mental state when she asserted that she wanted to die and did not want life-prolonging treatment. According to Section 11 of the New Zealand Bill of Rights, "a competent patient's informed and applicable refusal of consent... provides a lawful excuse for any omission to prolong life" [1]. This is reinforced by Right 7 in the Code of Patients' Rights, which states that "Every consumer has the right to make an informed choice and give informed consent" [2]. This right extends to the mentally incompetent patient who previously made an advanced decision while mentally competent. The medical team judged that Miss F. was of sound mind when she chose to refuse any potentially life-prolonging treatment. Furthermore Miss F. had also discussed this with her niece at length, and informed her of her wish.

Be that as it may, the question arises as to how 'confused' one must be for their decision to be invalid. What if one in the face of death, chooses to live, but is too confused or deemed too confused to make a valid decision? One's competency is an important factor that needs to be considered in such circumstances. Appelbaum described four criteria to assess competency: (1) the ability to clearly communicate one's decisions; (2) understanding the information about one's condition; (3) appreciating the consequences of one's choices; and (4) being able to weigh the relative risks and benefits of the available options [3]. In the event that one is deemed incompetent to make a decision regarding treatment, advanced directives or substitute decision makers are sought. Miss F. was confused when she later said she did not know if she wanted to be treated or given palliative support. She was floridly confused and delirious, and did not fulfil any of the criteria for competency. Hence it was felt that the first decision to withhold any potentially life-prolonging treatment should stand.

Medical treatment has obvious benefits to the patient. Treating pneumonia with antibiotics can directly prevent mortality. However in considering if treatment is beneficial or non-maleficent to the patient, quality of life following their treatment has to be deliberated too. Would the patient be able to return to their previous level of functioning or to a level of functioning acceptable to them? The team felt that Miss F. would probably never return to the level of functioning she enjoyed before her hernia operation and that even if she did survive this bout of pneumonia, she would not fully recover.

The consensus amongst the medical staff was to palliate Miss F. and not treat her pneumonia. Her name was no longer on our patient list the next day.

Increasingly, as medicine advances, we as clinicians will grapple with difficult and unpleasant dilemmas regarding the withholding of treatments which prolong life. It is in these situations that the ethics we explored as students in the classroom will manifest as uncertain realities. It is in these moments that you realise there are no simple guidelines or tabular algorithms to follow. It is in these moments that the art of medicine rings true.

REFERENCES

Ministry of Justice (1990).
NEW ZEALAND BILL OF RIGHTS ACT 1990.
Available: http://justice.govt.nz/pubs/reports/1997/bill-of-rights/section11.html?search=true. Last accessed 10 January 2009.

Health and Disability Commissioner. (1996).
The HDC Code of Health and Disability Services Consumers' Rights Regulation 1996.
Available: http://www.hdc.org.nz/theact/theact-thecodedetail. Last accessed 10 January 2009.

Appelbaum P.S.
Assessment of Patients' Competence to Consent to Treatment.
NEJM 2007;Vol 357:1834-40.