HEARTBEATS AND HEROES: NAVIGATING THE LABOUR ROOM

By Anisha A Nair,
Doctor at Government TD Medical College Hospital, Alappuzha, Kerala

"Hey, did you hear? We will be having labour room postings in our final year!"

I stared at my friend in disbelief. "Us! We know absolutely nothing!"

"Oh, don't worry, they will teach us everything. I think."

"Huh??? But we are still only med. students!"

I was never particularly interested in obstetrics and gynecology. I'd heard enough stories to know that obstetricians needed to be as tough as the women delivering in the hospitals to make a name for themselves in this specialty. It takes guts. And boy, I was not ready.

We had a total of four weeks of postings with 12-hour shifts every day. They were meant to familiarize us with the labour room: to understand its operations and how to care for pregnant women. More specifically, to know what needs to be done when they go into labour.

One of the first skills I acquired during my postings was drawing blood. It was a tricky process, especially if the vein was not superficial. However, once we saw the hint of red enter the hub, confirming that the needle had entered the vein and hence our success, we would tingle with joy and brag about it to the others who would look on wistfully, hoping to attain the same skill in the near future.

If I were to describe the labour room in one word, it would be "chaotic". To monitor fetal well-being, we had machines that checked fetal heart rate. The tests were called "non-stress tests" (NSTs) and "cardiotocography" (CTGs); the main difference being that NSTs were taken when the woman wasn't experiencing contractions, while CTGs were taken during contractions. In my hospital, we had four different rooms to categorize the pregnant women based on their stage of labour and progress. The first room was for monitoring the women before their contractions had begun, and thus we were entrusted with the task of monitoring their blood pressure, pulse, and NST to ensure that both the mother and fetus were faring well.

However, one thing we were blissfully unaware of when we first entered as interns was that in the first room, we also had patients diagnosed with intra-uterine deaths and ectopic pregnancies awaiting treatment and they were kept in the labour room for close monitoring. One of my friends accidentally tried to record an NST for a patient with an intrauterine death but the machine was unable to detect a heartbeat. She tried placing her stethoscope at different sites to locate the heartbeat and managed to hear some tinkling sounds, assuming it was the heartbeat. Unbeknownst to her, they were actually the bowel sounds of the patient! The patient, on the other hand, kept the information about her condition to herself, hoping that perhaps her baby was alive and that the machine would pick up the heartbeat. It was rather unfortunate, but later we called her over when the situation came to our notice and apologized to the patient for the trouble. If any of the women started developing contractions and pain,

we would shift them to the next room, where we would monitor how long the contractions were lasting and review the CTGs to ensure there was no fetal distress. Once the contractions started lasting longer and the frequency increased, we would look for crowning, which is the term used to describe the stretching of the vulva by the fetal head. When that was detected, the doctors would yell "SHIFT" at the top of their lungs, and the attendant would rush in with a wheelchair to shift the woman to the delivery room.

In the delivery room, the woman would be placed on the table in a semi-reclined position with knees bent. The staff would get ready for the delivery, and we would all chant "PUSH" in unison to encourage the mother. We would then look in awe as the baby's head appeared, followed by the body, and the baby would start crying for air as we all collectively ushered the little one into the world. Following the delivery of the baby and placenta, and ensuring both the mother and baby were healthy, they would be shifted to the last room: the postpartum ward, where we were once again tasked with monitoring the vitals and ensuring the mother was fine and had no excess bleeding. Contrary to popular belief, the job isn't done once the baby is out. While we, as interns, usually gathered around the warmer where the baby was placed to adore and play with it, begging the nurses to let us hold the infant, the doctors would be busy performing the episiotomy stitches, monitoring the exhausted young mother's vitals, and cautiously ensuring the placenta was delivered.

Within 30 minutes of the baby's delivery, the placenta must be expelled completely. However, there are moments when it refuses to come out, and we are required to intervene. The medical term for this condition is "retained placenta". One such incident occurred during my postings where the placenta stayed inside, and we were forced to shift the patient to the operating theater, give her anesthesia, and remove it manually through the vagina. Since it was our first time seeing such a case, my friend and I rushed to the theater to observe and assist with the proceedings. Our professor seated herself grimly at the table, inserted her doubly gloved arm into the vagina, and began actively searching for the placenta. She managed to feel the edge and tried to remove it, but the placenta didn't budge.

The ultrasound was able to locate the placenta, and it was revealed that the placenta had not yet detached from the uterus. That's when everyone in the room broke into a cold sweat.

The placenta had to come out no matter what, or it could lead to several complications, including hemorrhage, shock, and death if left untreated. And the clock was ticking. My professor resorted to calling the senior professor and explained the situation. Within 15 minutes, she arrived and was scrubbed in. All our eyes were on her as she began searching for the placenta. We waited with bated breath till finally, my professor withdrew her arm with the intact placenta in hand, and a wave of relief washed over the staff. My friend grabbed my arm, almost in tears over the fact that the placenta was finally out. I smiled back, realizing that our professor, much like a superhero, had saved the day.

The experiences in the labour room were both challenging and enlightening, teaching us not only the technical skills needed for obstetrics but also the emotional resilience and empathy required to support patients through one of the most significant moments of their lives. I witnessed the dexterity and swift decision-making skills of my professors, who provided physical and emotional support to the women in a professional manner. I was also exposed to the raw fear and excruciating pain the mothers were experiencing, and I gained a lot more respect for all the new mothers who were willing to go to great lengths for their babies.

Our initial fear and uncertainty gradually transformed into confidence and competence as we navigated the complexities of childbirth, from the chaotic early stages to the critical moments of delivery. The labour room is a hub of mayhem where complex emotions clash like turbulent waves, yet with the help of doctors and nurses who thrive amidst it all, we safely welcome new mothers and future generations.