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Commentary

An obstetrician reborn

R Garry

Médecins Sans Frontières, Sydney, NSW, Australia
Correspondence: Dr R Garry, Médecins Sans Frontières, PO Box 847, Sydney NSW, Australia 2007. Email raygarry@btinternet.com

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Introduction

How many obstetricians have lost the focus and motivation that took them into the specialty? How many more have happily given up the discipline altogether and no longer the use the practical skills that they have gained so painfully over countless night-time hours? I was certainly one of those doctors.

I had decided to be an obstetrician from fairly early in my medical training and was fascinated by the drama and excitement of childbirth. No moments in all of life condenses so much meaning and importance into such a short period of time. The uncertainty of outcome makes the subsequent feeling at a successful birth a time of intense exhilaration. Even the most cynical of attendants cannot fail to raise a smile at the arrival of a much-wanted newcomer.

The question: why is the practice of obstetrics often disappointing?

Given these very positive feelings, why did I and so many other obstetricians so willingly give up the discipline midway through their careers? Some of the reasons have been well explored. Was it the demanding commitment of repeated nights on call throughout a career? May be a little, but this problem is gradually being solved and was not a primary consideration for me.[1,2] The fear of litigation and the costs of malpractice insurance are other commonly quoted reasons for giving up.[3,4] This remains a constant if manageable fear for most obstetricians. Was it rather because I had exciting opportunities to explore new fields? Certainly, at least in part: I became completely committed to Minimal Access Gynaecological Surgery and was privileged to spend most of the rest of my career in a satisfying and rewarding career exploring ways to make gynaecological surgery safer and better. Another major reason for giving up obstetrics was that antenatal care had become professionally less rewarding. This aspect of personal drive is little discussed but I suspect it is a major cause of defections from front-line obstetrics. I was mostly removed from the immediacy of hands-on-obstetrics. I supervised very large antenatal clinics with a basically healthy and normal population. Ever-greater numbers of tests and forever-increasing numbers of low-incidence problems. More and more demands for lifestyle interventions and more complaints when these plans were not fulfilled. I felt more like a busy and not very well appreciated administrator on a production line rather than a doctor using difficult to obtain obstetric skills. It was only years later that I recognised that this personal feeling of disillusion was widespread among the profession and that the combination of too much paperwork, administration and hassle and less direct patient interaction made practice not as rewarding for many doctors as it had previously been.[2,5]

My personal answer to this situation came recently in an unexpected manner. I was not ready to give up work completely when I retired from full-time practice. After a period of formal Royal Australian and New Zealand College of Obstetricians and Gynaecologists-approved obstetric upskilling I began to do some short-term locums in obstetrics in rural and remote areas of Australia. This was primarily to enable me to spend more time with my daughter and family who lived in that vast and far away land. The principle motivation for this move was initially financial but to my surprise I found I also rediscovered enthusiasm for practical obstetrics. Obstetrics as a locum with no administrative duties and all of my time devoted solely to patient care was really invigorating.

The facts: childbirth remains dangerous

Then one day I glimpsed a dreadful reality through an introduction by the agency that arranges my Australian locums. They advertised on behalf of the charity Médicins Sans Frontières (MSF). This advert described the urgent need for obstetricians to work in some of the world's most deprived countries. The data are shocking. I was assigned to work in Sierra Leone, which is one of the poorest countries in the world. The overall life expectancy there is only 47.5 years

and the maternal mortality is among the worst in the world with a rate in 2008 of 1033/100 000 compared with 8/100 000 in the UK and 4/100 000 in Italy.[6] It is one thing to read about these statistics as abstract ideas but it is quite another to be confronted with them on the ground. The work there brought me face to face with some realities of obstetric care and reminded me of just how dangerous childbirth can be.

On my first day on call I undertook six deliveries including three caesarean sections. Of these, two women had severe eclampsia and two had major placental abruptions. One of the women with antepartum haemorrhage was a 35-year-old Gravida 8, Para 2 (a normal ratio in Sierra Leone) who had massive intra-abdominal and revealed bleeding that resulted in her developing disseminated intravascular coagulation. We had only a very rudimentary transfusion service that depended on the individual woman's family to provide blood. We had nowhere near enough to keep up with her blood loss and I could only watch as this strong woman gradually lost consciousness and suffered a cardiac arrest. I will long remember her wide eyes staring at me as she bled to death. Not the start to my MSF mission that I had hoped for.

On another day on call I was confronted, not only by the range of severe obstetric complications that can occur in this type of environment, but also by some profound ethical issues. Three women were admitted almost simultaneously, each exsanguinated. The first, a young woman of very short stature who had a prolonged obstructed labour in an outlying village managed at first by local attendants. After several days in labour she presented with a ruptured uterus that we were able to repair. This apparent success was later followed by the development first of typhoid fever and then a vesicovaginal fistula and a neuropraxia resulting in foot drop. Returning to the fateful day we had by this time depleted our meagre blood stocks. As I emerged from the operating room I was confronted with a 14-year-old girl who had collapsed with what was thought to be an ectopic pregnancy. She was profoundly shocked and deeply unconscious. There was also a more mature woman of 28 years with five living children who had delivered hours earlier in her local village and had developed a postpartum haemorrhage. She also was shocked and unconscious. Both of these women were dying of blood loss and I was alone, without any immediately available blood. Which to concentrate on? I elected to work first on the young girl who was found to have not an ectopic but a tear in the back of the uterus associated with an illegal abortion and a quite large fetus and placenta lying in her lower abdomen. I repaired the rent in the back of the uterus, removed the products and blood clot and secured haemostasis. Despite this operative 'success' she remained deeply unconscious and continued to have a high temperature that was resistant to triple antibiotic and antimalarial therapy. It took us 3 days to recognise that she also had Lassa Fever, from which she died 14 days later. Meanwhile, the 27-year-old lady with the postpartum haemorrhage, who was obviously potentially saveable but who was inadequately resuscitated, had died while I was with the younger patient.

This work was undertaken near Bo, the second city of Sierra Leone, in the MSF Gondama Referral Centre. The hospital was originally a centre for refugees and casualties of the dreadful 10-year civil wall that destroyed much of the country's infrastructure and damaged much of the population physically (many amputations of arms and legs by the 'child soldiers') and mentally (many rapes and extreme sexual violence). MSF converted some of the camp into an 'emergency' children's and maternity hospital. The maternity service provides only acute care for abnormal labours. There are no antenatal care facilities and 'normal' labouring women are not admitted. The obstetricians are all from overseas ('expatriates') but the remainder of the staff are local 'nationals'. They include a team of well-trained nurse anaesthetists, and some good nurse operating assistants. There are also midwives, nurses and anciliary staff of varying degrees of competency. The three 'expatriate' obstetricians, who share the workload, spend 24 hours on first call, which usually involves absence of sleep for that period. This is followed by a day off to recover and the third day is a normal second on-call 8.00 a.m. to 5.00 p.m. shift. The average 'mission' last from 3 to 6 months and the makeup of the staff is constantly changing. During my 3-month stay, four of the five obstetricians were in the peri-retirement phase of their career. At one stage the three of us, from Germany, USA and UK, had a combined experience of 125 years and during this time none of us had ever seen a direct maternal death during delivery. Only one of the five was younger and in active practice and she was a remarkable young woman who was still in training. The timing of when to undertake such work is problematic. The physical demands are considerable and inevitably associated with sleep deprivation that is probably best dealt with in the younger phases of life. The severe emotional demands conversely are perhaps better dealt with by more experienced and older doctors. Ideally those in the middle of their working life with both vigour and experience would be preferred, but obviously this mid-career stage is when work, financial and family commitments all pose their greatest demands and make volunteering most difficult. These demands mean that it is difficult for most of us to sustain such a mission for long periods of time. I certainly found that the combination of heat, humidity (it was the tropical rainy season), sleep loss and the draining effects of the professional challenges made me ready to return home after my 3-month commitment. After a short period of rest, however, I became aware that the challenges I had faced and the people I was working with had affected me and I am keen (my wife permitting!) to undertake further missions.

Doctors and nurses make up less than half of the expatriate staff in an MSF mission. The remainder are the support teams or logisticians. This inspirational group of highly skilled and motivated people give up their often lucrative careers to provide power, water, sanitation, food, buildings, money and medical supplies that are often all absent in the local community yet which are essential to ensure that our medical interventions can be undertaken. Working with them was a humbling experience.

In Sierra Leone the vast majority of the women we treated had little or no antenatal care and this was associated with a 1% chance of dying during a specific delivery and a 1 in 8 lifetime risk of dying from pregnancy-related conditions. There was also a 20% risk of being admitted with a fetus that was already dead *in utero*. The population served was mostly very poor and some were malnourished. The area was hyperendemic for malaria with 50% of the women being ParaCheck-positive for malaria during labour. Some 10% were positive for syphilis and around 10% positive for HIV (but no screening programme for this was in place) and there were also a whole list of other exotic tropical diseases complicating the health of women.

During my 9 weeks of active practice (I was medically evacuated for high-risk exposure to Lassa Fever for 3 weeks in the middle of my mission) I performed 55 caesarean sections, repaired four ruptured uteri, undertook three caesarean hysterectomies, managed malpresentations including a breech trapped by the head and hanging out for 2 days as well as hand, arm, foot and shoulder presentations. I also undertook a single destructive delivery for a long obstructed labour that was associated with evidence of uterine infection and longstanding death of the fetus. Massive bleeding from both placenta praevia and placental abruptions was common and managing eclampsia was an almost daily occurrence. I also dealt with three ruptured ectopic pregnancies and a distressing number of infected abortions of which three were associated with tears in the back of the uterus. I also directly managed four of the seven maternal deaths that occurred during my time in Africa. These findings were similar too, although rather worse than, those reported previously in various areas of West Africa.[6]

A possible answer: active clinical obstetrics without other roles

This experience was variously the most intense, distressing, stimulating and rewarding period that I have experienced in my 45 years as a doctor. It was solely a birth-centred job. These feelings that clinically centred practice is what we should be doing may not just be an individual quirk of the author. There is some suggestion that posts whose sole focus is to manage women in labour (labourists!) improve career satisfaction for some obstetricians[7,8] but clearly such views need much more evidence to justify their systematic introduction.[9]

My return to intense labour ward practice was associated with a massive boost in my own work satisfaction. It is not clear if working in such high-risk areas is suitable for every individual and personality type, but I suspect that all who are capable of coping with the demands of modern Western obstetrics would be able to develop adequate coping mechanisms. This was definitely true of the five very different personalities working in Bo during my stay. To those who are jaded by current practice demands, I strongly recommend a period working for a non-governmental organisation such as MSF. It can be argued that such interventions by non-governmental organisations are counterproductive and may just induce a dependency culture in the recipients. I cannot judge if this is the case on a national or international scale but I give this final case as an example of the benefits of such interventions on a personal level.

For every disaster of the type described above there were, of course, many more successes. The last patient I saw before returning to the UK was a woman who had lost all of her four previous pregnancies with intrapartum deaths of unknown causes. When admitted to our ward she was found to have a prolapsed cord with many loops lying in the vagina. A further tragedy seemed inevitable but we rushed her to the operating room and were able to extract a living baby within 15 minutes of her initial admission. Such a diagnosis/delivery time would have been remarkable in a developed world, state-of-the-art unit. To achieve this in an area of such deprivation was amazing. I pondered on just how many people had contributed to this brief moment of success. All the many financial donors who provided the funds, the MSF management teams in Europe and Sierra Leone who coordinated the work, the chain of logisticians across the world whose efforts made available all the equipment and facilities needed to successfully complete such a rapid operation along with the well-trained and motivated local nurse anaesthetists, nurse theatre assistants and midwives all contributed to this isolated moment that enabled the saving of this one infant, to give joy to one family, and particularly one very excited grandmother, and to remove at least one bad statistic from the list of obstetric disasters that affect so many women in the disadvantaged parts of the world.

Conclusion

In conclusion I believe that antenatal care in developed countries has become professionally less rewarding for at least a proportion of obstetricians. Developing an option to drop administrative duties and regain clinical skills perhaps concentrating on those who need them most may be of benefit to both patients and their attendants. Working in an area of great need may refresh and recharge the clinicians'

enthusiasm. My experience has certainly demonstrated that in large parts of the world childbearing and birth remain very dangerous. I am grateful to have had an opportunity to become a born-again obstetrician and to have worked with the dedicated members of MSF and the stoical, strong and wonderfully cheerful women of Sierra Leone. I hope that sharing my experiences may help some others to renew their enthusiasm and focus for the speciality.

Disclosure of interests

I declare that I have no interests to disclose in relation to the contents of this paper. ■

References

1 AMA Managing the risks of fatigue in the medical workforce. Safe hours Audit 2011. Australian Medical Association July 2012. Barton ACT audit 2011.

2 Bettes BA, Charles E, Coleman VH, Schulkin J. Heavier work load, less personal control: impact of delivery on obstetrician/gynecologist career satisfaction. *Am J Obstet Gynecol* 2004;190:851–7.

3 Rosenblatt RA, Weitkamp G, Lloyd M, Schafer B, Winterscheld LC, Hart LG. Why do physicians stop practicing obstetrics? The impact of malpractice claims. *Obstet Gynecol* 1990;76:245–50.

4 Ethical concerns and career satisfaction in obstetrics and gynecology: a review of recent findings from the Collaborative Ambulatory Research Network. *Obstet Gynecol Surv* 2011;66:572–9.

5 Gundersen L. Physician burnout. *Ann Int Med* 2001;135:145–80.

6 Hogan MC, Foreman KJ, Naghavi M, Ahn SY, Wang M, Makela SM, et al. Maternal mortality for 181 countries 1980–2008: asystematic analysis of progress towards Millennium Development Goal 5. *Lancet* 2010;375:1609–23.

7 Weinstein L. The laborist: a new focus for practice for the obstetrician. *Am J Obstet Gynecol* 2003;188:310.

8 Committee Opinion no 459. *Obstet Gynecol* 2010:116:237–9.

9 Srinivas SK, Lorch SA. The laborist model of care: we need more evidence. *Am J Obstet Gynecol* 2012;207:305.