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This is a resident case log of a patient encounter in which an "Aware Medicine topic" was central.

Delivery Via Phone Interpreter

An OB patient was pushing. Her cervical dilation, effacement, and station were unknown. She is a Hmong woman, 43 years old, who has had two previous pregnancies. She arrived in triage uncomfortable and wanting to push. When she arrived, I was in another delivery. After this, I was called immediately to a second delivery. The backup resident was present and gracious enough to tend the patient along with the Family Medicine attending while I was occupied. When I arrived in the room, the patient wanted to push, and from all visual indications was indeed pushing. At her last cervical check, she was not yet complete. Her husband was present. Neither spoke English. We had a language line interpreter on the speaker phone. She was resistant to cervical examination. With help of the interpreter, we were able to negotiate with patient and husband. Cervical exam was performed, and she then labored and pushed in squatting position and baby boy was delivered.

While I was concerned about the danger of the pt pushing through an unfavorable cervix, I both believed in her sense of knowing and respected her desire for as little intervention as safely possible. We watched the fetal heart tones and these remained reassuring. In this context, I was comfortable with the time taken to negotiate a process for checks, labor, and eventual delivery.

It's difficult to approximate another's beliefs. I think I ran a middle line between those who wanted more intervention and the pt who wanted less. The pt had 2nd degree vaginal laceration, non-bleeding. She desired no repair. No repair was performed. Baby boy delivered with thick meconium. The cord was clamped, cut, baby taken to anteroom where he was suctioned and stimulated. APGARs were normal. After the birth, husband and wife were joyful. Husband made a point to take me to the speaker phone and thank us for our work.

Three things I felt good about:

1. Maintained contact with couple, respecting their wishes.
2. Worked with attending to help mother labor in way she desired.
3. Delivered the head, primarily by feel, in squatting position. Protected head and neck as mother transitioned into supine position, then delivered torso and legs.

Early on I felt frustrated that I didn't have a sense whether or not the labor was proceeding safely and that I couldn't communicate directly with the patient. Nurses were asking whether or not she could push while it seemed obvious that she was pushing. When advised we needed to perform a cervical exam, the patient said, in Hmong, "no". Well ... OK. hmmm ... just "no". Baby looked good on the monitor, so that eased the degree of urgency and provided some relief. The patient had delivered babies before and was rooted in a culture with strong beliefs. From there, I moved into a different space. I knew that I could advise and would suggest more strongly at points I perceived more critical, but this was truly a partnership and I was not in full control, which was fine.

In the future, if this were to occur, I would try to get an interpreter on site early in the evolution of the process. From there, the situation was fluid and would be difficult to replicate or prepare for. In terms of the delivery, there was not enough room between the patient's vaginal opening and the bed to deliver the child. Next time, I would ask that the patient change positions earlier in the process to allow room for delivery without a mid-delivery position shift.