

Description

The Breath of Life: is really optional

Pandora Hardtman is currently employed as a Midwifery Capacity Building Consultant for the Syrian Conflict. She has gained over 23 years of nursing and midwifery experience whilst working in a wide variety of healthcare settings in the USA, Caribbean, South East Asia, the Middle East and Africa. Her global work centers around building supportive clinical training and policy frameworks for Midwifery Education, Regulation and Association.

Another time another place

The time of year rolls around all to quickly for the mandatory CPR and NRP re-certifications. We sigh, make jokes about kissing Annie and place another paper card in our wallets or e-files.



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Inside our hearts, many of us pray that we never have to really use the ventilation skills learned. We may even have become a bit cynical after years of checking the box on the renewal cycle, because for most of us, the rush of the paediatric team is only a button push away.

Resuscitation is a key nursing and midwifery competency skill that has been drummed into us so many times that most of us could perform the actions in our sleep, despite not really wanting a ‘bad baby’ in our hands after birth.

Let us spin the globe to another time, another place.

A rapid assessment of nursing and midwifery care providers in a current ongoing low resource /humanitarian conflict revealed that none of the nurses or midwives knew how to put together or use a bag -mask device for newborn resuscitation. The concept had been introduced in school, but with no access to ambu- bags, the skill remained an elusive idea on paper. In my work over the years as a global nurse-midwife, I have personally seen this scenario repeated over and over in countries and settings across the globe.

Reflect a minute on the fact that these are the nursing and midwifery care providers that are alone in the remote health centers. They function as the first line of defense for immediate care of the newborn, or consider that they are delivering at home alone under the ruble of a ruined infrastructure. Why are there so many stillbirths some ask? Well…

Reality Check. Case Scenario

So, what's a midwife to do when transport is 3 hours away and there are only 10 NICU beds in the city anyway? Or, if in fact, the main city is destroyed and you are in a tent? The life and death decisions that then have to be made, with the sight of a head on the perineum. This birth has turned into a prayer, God willing, Inshallah.

Let us consider our options, to initiate possible transfer to a higher-level facility far, far away down a long dark dirt road or not to bother? How long to ventilate the "flat" infant knowing that you have no medical resources either human or facility to maintain a high needs infant. To tell the truth or not, to the waiting family about the lack of materials that contributed to the infant death? Or to recognize that you are forced to work with filthy, broken equipment, but, there is nor water or no other option for the women and infants, other than your bare hands?

Reality check. Case scenario

A mother is transferred from a Health center to Hospital for care. History reveals a "precious pregnancy' with one other full term loss after a cesarean birth. The decision is made to perform an emergent repeat cesarean birth due to previous scar and decreased fetal heart tones in the 100's. There is a surgeon, midwife first assist, anesthesia, and scrub nurse in the theater. The infant is delivered. The mother is told that the infant is dead. The infant is sent home to be buried within a 24-hour time frame as culture dictates. Several hours later, the grandmother rushes the breathing baby back to the hospital. Treatment is begun for the infant in the bare bones neonatology unit. Several hours later, the infant is pronounced dead for the second time. The family brings a complaint to the authorities and all of the health care providers involved in the case are thrown into jail prior to investigation. Lazarous syndrome is the final diagnosis.

A full term neonatal death caused by breathing difficulties is something that most Midwives working in the Western world will never experience. A neonatal death or fresh stillbirth is a daily occurrence for our Sister Midwives in another time/another place. Midwives are so accepting of this norm as their reality that investigation of the case briefing mentioned above reveals that none of the health care providers in the room attempted resuscitation when the baby was born flat and not breathing. Upon receiving the depressed baby, the assumption was made by all health workers that the baby was dead and the mother duly informed. Not one of the 5 providers present in the room questioned this finding or action. No one said – Maybe we should ventilate. Each health care provider claimed that they had no role.

Thoughts

My lived experiences as midwifery first assist who faces a depressed baby recall well the panic in your heart as you dash to the ventilator with a non-responsive infant. You are ever so happy that the NICU team is present to intervene. Until the first cries are heard across the room, you have a personal diagnosis of tachycardia as you hold back the fascia. I recall even dropping the retractor to go and help with the resuscitation if needed on more than one occasion. No one wants a dead baby, emotionally or legally.

In that operating theater in a place far away, no one tried or even thought to try breathe 2-3, breathe 2 -3. In another place, nurses and midwives never learned the skill because only paediatricians who don't attend birth may be taught.

Or the schools and hospitals simply don’t have the very inexpensive equipment to train or maintain health workers in the skill. How do the Midwives carry on when maternal and infant death is the norm? To CPR Annie, and your progeny Mama and Neo-Natalie…

Thanks we really do love you!

Twitter: @pandoraHardtman

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1. low resource settings
2. neonatal resuscitation
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