Human Skills

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Wind roared past my ears as the boat sped towards an unknown destination, to an unnamed patient. The only thing we did know was that we had to get there. Fast. Less than an hour previously I had walked into the obstetrics ward in a rural Papua New Guinean hospital, hoping a woman in labour was waiting for me inside. How naïve I was; after 5 weeks I should have known to expect the unexpected. There was a woman in labour, but she was in a village down the river from the hospital and had delivered one twin at 10pm the previous night, and now, 13 hours later, still had not delivered the second twin. The hospital had no boat, and the walk to the village was hours through the jungle, so there was nothing the nurses could do to help her. Laura, my fellow medical student, pulled out her phone and was already messaging Jamie, the volunteer doctor from Australia who had taken us under his wing. He replied instantly: he had organised a boat and would pick us up from hospital.

The boat slowed down as we approached a riverbank. The driver yelled out to a woman in Tok Pisin, and I could roughly make out that he was asking whether a woman with twins was in their village. He pulled the boat to the side; I guess the answer was yes. We passed an impressive wooden structure that housed about 12 people, but my attention turned to two vertical wooden poles with a tarp between them a little further down the track. There was nothing else around. The village was one house. I wondered whether the woman was behind the tarp; but deep down I knew the answer already and tried to brace myself for what I was about to see.

A woman lying on her side in the dirt, in a pool of her own blood, barely able to open her eyes. Next to her, two newborn babies, cords unclamped and dusted in dirt, exposed to the world. Towering over them, a crowd of villagers watching impassively but not helping. I dropped my bags in the mud and gathered the smaller of the twins, feeling every rib as I held him to my chest. Despite the humid air, he was cold. Shallow breaths highlighted his emaciated abdomen. I asked the bystanders for clothes, anything to cover the baby and warm it up. No-one responded. I pointed to the clothes on the line and promised I would return it to them after. Again no-one responded. It felt like I was the woman lying in the dirt, surrounded by people excited to watch the drama but no-one willing to help. We clamped the cords, wrapped up the babies with what we could and made a stretcher out of the tarp previously sheltering the woman. We rushed her to hospital, stabilised her with more fluids and blood then repaired her perineum. We weighed the twins. Twin 1 who had been laying in the dirt, bleeding out of it's umbilical cord and unfed was 1.1kg. Twin 2 who had been born an hour before we got there, but 14 hours after twin 1 was 1.5kg. They needed food. I asked the mother if we could try *susu* (breastmilk). Despite our efforts, the newborns lacked the strength to latch on. We needed to put a nasogastric tube in, and we needed formula. In a hospital that was running out of essential antimalarials, it was no surprise there was no formula. Jamie and Laura rushed to the shops to buy some formula, and I stayed to wash the babies. As I lowered twin 1 into the warm water, he opened his eyes and

looked into mine. I didn't break the stare. One day old and emaciated, he should have looked vulnerable. But that wasn't what I saw when I looked at him. I admired twin 1. He had survived 14 hours without food, warmth and all the while lying in a growing pool of his own blood from the unclamped cord. He was a fighter.

The next day Laura and I walked into hospital, motivated by a feeding regime we had devised overnight. As we were walking into the maternity ward, we walked in on a moment which made us forget about our plans. Our mother, who had no visitors and no family to support her, was being taught how to breastfeed by another patient on the ward. This patient was also meant to be a mother but had lost her baby just hours after birth. What a contrast. In the mother's village, we could not get a single piece of cloth donated to warm a freezing baby. In hospital, a woman who had just lost 9-months of excitement, anticipation and love, was teaching our mother how to breastfeed. Later this same woman would donate her own expressed breastmilk when our mother had trouble producing her own.

From that moment, a routine started. Every 3 hours I would check the nasogastric tube placement, make up a fresh batch of formula, test the temperature on my skin to make sure it was the perfect warmth, and ensure all the antibiotics were being given on time. I would sit on the edge of the mother's bed while I syringed the formula through the tube and try to converse despite the language barrier. *Nem bilong pikinini?* (what's babies name?) I asked one day. With a smile, she said Jamie. The language barrier melted away; I knew exactly what she wanted to say.

We soon realised that unlike all the other new mums whose family could barely fit on the ward, Jamie's mother had no visitors, and it became clear that there was no-one bringing her any food, clothing or hygiene products. Laura and I made a habit of daily food drop offs, clothing and sanitary pad donations. The first time we handed her a soup mix packet, she mixed it with cold water and drank it before the kettle finished boiling. Perspective is an interesting thing; I thought back to the patients at the metropolitan hospitals I've done placement at previously and recalled the failsafe icebreaker about how unappetising hospital-provided food was.

On Thursday morning, we walked into the ward but something was different. The normally giggling and happy nurses looked troubled and my heart sank instantly. Jamie had died at 7pm the previous night. He had an apnoeic episode and the nurse on duty spent 3 hours trying to resuscitate him.

Medical school teaches you that problems have solutions. If the current blood pressure medication isn't working, we can increase the dose, or add another medication. There are protocols and policies and flow charts that show you there is the gold standard, then plan B, then plan C. This was the first time I had ever faced a medical scenario where there was no plan B. There was nothing we could have done. No other hospital or specialist to refer to, no other equipment or medications we could have tried. This wasn't how medical school had trained me to think. There were no case based learning scenarios that ended in us being unable to do anything.

I walked over to Jamies' mum's bed, not sure if there was a word in Tok Pisin, or English for that matter, that could describe the way I felt. In a true testament to her bravery, she, the woman who just 12 hours previously lost her baby, smiled at me as I approached her. Maybe I didn't want to believe what Jamie's mum said to me in that moment, or maybe my Tok Pisin was just atrocious, so I asked the nurse to translate. Jamie's mum was asking me to clean and dress Jamie so the body could be sent back upstream to her village. It was far beyond what would ever be asked of a medical student in Australia. But it made sense, I had cared for Jamie when he was alive, washing and feeding him daily, so who else would do it? As I washed the mottled, stiff body I could almost convince myself that he was still alive, any small move causing a ripple of movement through the rest of his tiny body. I dried him and dressed him in oversized clothes, meant for a newborn three times his size.

After lunch we returned to the ward, to an atmosphere that paralleled that of this morning. For the second time that day I braced myself to hear the worst, as the nurses informed me one of the mothers in labour had no foetal heart rate on ultrasound. I wanted to run away and scream that it wasn't fair. But I didn't run away, and I didn't scream. I looked at the delivery room door and contemplated my experiences over the past few days.

My perspective had changed. Something was different this time around. The experience with Jamie had changed me. Even though we couldn't save Jamie, we had made a difference. I thought I was studying medicine to save lives; but what if that's not it at all. What if it's that I get the privilege of seeing someone in the darkest days of their life and have the opportunity to make it a little less frightening. Even if I can't always save lives, I have the opportunity to help others feel safe, and cared for.

We as medical professionals can offer a lot more than our pharmacotherapy limits us to. For Jamie, antibiotics may not have been enough but it is not only the clinical skills we learn that make a difference. We spend a considerable amount of time learning about human skills like empathy, compassion and breaking bad news. It was with compassion that we brought in food for Jamie's mum, patient-centred care which saw me feed Jamie by his mums side so she got to spend more time with him when he wasn't in the incubator, and non-verbal body language that established rapport in the presence of a language barrier.

Our human skills are what keep us medical professionals with skills to contribute even if we don't have a paracetamol pill to our name. Perhaps that's one of the most valuable tools we have, because for once the only limits to their use are the ones we put on ourselves. You don't need to be in a first world country to access these tools, you can be in a village in the middle of rural Papua New Guinea. In medical school it is easy to get caught up in the physiology and theory behind diagnosis and management. But sometimes none of that matters.

The experience taught me that sometimes medicine is not just knowing the diagnosis or the algorithm, it is the human connection and support we can give in difficult times. Sometimes, even if we have the best medications and treatment options, we still lose the patients we care for. Maybe that's why medical schools invest thousands upon thousands of dollars into bringing actors in for us to practise our human skills. Because they know there's a time when medications aren't enough and talking to the patient means everything.

I stood facing the door of the delivery room. I couldn’t change that the woman’s baby would be delivered stillborn, but I could still change the outcome of the story. The woman didn’t have to grieve alone. Even though there is a limit to what medicine can achieve, there is no limit to what we as humans can achieve with compassion and continued humility to our patients. I took a deep breath in, and pulled open the delivery room door.