The morning of my first 24-hour call, I walked past the giant window on the fourth floor of the hospital en route to see some more postpartum patients. The fourth floor is home to the labor rooms and the other wards whose purposes are born there – postpartum, newborn nursery, and the NICU. The window stretches across the lobby that connects the two halves of the floor and provided me a daily glimpse at the foliage laid out below. I tried to remember what the temperature had been as we’d hurried into the hospital that morning.

My Ob-Gyn rotation occurred at the end of the semester, as the weather turned in the most abrupt but typically North Carolinian way from warm to cold, betraying any intermediate suggested by the colors of the leaves. I had gradually worked my way backwards through the human life cycle, rotating through Internal Medicine, then Pediatrics, and finally found myself at its beginning. Obstetrics had a distinctly more surgical feel, requiring fewer but more focused details about a higher volume of patients than I was used to. On postpartum rounds, I asked every woman about lochia, appetite, and ambulation; I palpated each uterine fundus to make sure it was firm, and dug my fingertips into twice as many lower calves to make sure they weren’t pitted or showing other signs of brewing clots.

During the previous year of medical school, while still classroom-bound, I led the Ob-Gyn student interest group and attended the district meeting of the American Congress of Obstetrics and Gynecology. I took advantage of every opportunity to gain exposure to the field. I tied surgical knots in shoelaces, used a laparoscope to pick up paperclips, performed a dilation and curettage on a papaya, and delivered half a dozen ungendered plastic infants from model pelvises, legless and inflexible. I used vacuums and forceps on their plastered heads, suture lines carved such that we, future obstetricians, could assess the angles of their occiputs. I did everything I could to prepare for the real thing – my first chance to deliver a baby.

I looked forward to my call that night – I would be working with my favorite senior resident and intern. Given that Ob-Gyn is distinctly female-dominated, I imagined it would be like a slumber party with purpose; much of our conversations during the last few days about pelvic anatomy, preeclampsia, and cervical cancer screening had been interrupted by gossip and read-alouds from US Weekly. Having only been on my rotation for four or five days, I was still equally consumed by efforts to fit in with this cadre of smart, impossibly well-groomed women and polish my presentations of patients during morning rounds.

The day passed steadily – there were two or three women laboring most of the time. Every couple hours, we would check in on them to assess their progress. I learned that my role was to get out a sterile glove and lubricant, opening the packages of each for my intern and laying it within reach so that she need only grab the unsterile inside with her left hand and push it onto her fingers with a snap. Fingers would dip into the gel, then into the patient’s vagina. “Six centimeters, complete, and minus one,” the intern would report to the nurse and I, who would record the dilation, effacement, and station
in our respective charts. Some words of encouragement directed at the patient regarding the progress of labor would usually follow, or strategizing if the progress was insufficient.

Between cervical checks, my residents and I would retreat to the lounge, where we’d sit on chairs fringed with surgical sutures, secured with hundreds of practice knots. My senior was a matter-of-fact brunette with near-bulging blue eyes who had trained at the University of Vermont. “My sister is going to deliver her baby at UVM next month!” I told her. I explained how Kelsey’s small and understaffed local hospital wouldn’t let her attempt labor after having had a cesarean section with my nephew. She had been commuting to Burlington, an academic center, for all of her prenatal care.

“My twin sister is pregnant and is due next month too!” my intern said, as excited as I was. We continued our chatter and I felt myself relaxing into the day.

Throughout the morning and into the afternoon, each woman labored predictably but many were primiparous, or “primips” as we called them. These first-time mothers frightened me because of their pain, their tearing, their unreasonable requests to pull the babies out, and their exasperation when we told them that this wasn’t possible. As a medical student, I was confined to the realm of uncomplicated deliveries, which also excluded the vaginal birth after cesarean, the HIV-positive mother, and the bitch, all of whom we encountered throughout the day.

Instead, I dutifully held the laboring mothers’ knees back and coached while all eyes were fixed on their vulvas, bathed in the artificial light of a floor lamp positioned behind the physician’s shoulder. During particularly prolonged or painful deliveries, I focused on the details of the mothers’ anatomy to distract my pelvic floor from its tendency to kegel in empathy. The labia on L&D come in all varieties – dark and pale, some ruffled, and curtained with varying amounts and styles of hair, from mohawked to bare; we’d shout “push, push” or “empuja, empuja” according to the language groaned at the other end of the bed.

After witnessing five or six successful deliveries, I knew when to hand over scissors and clamps and I had brought several glistening, purple placentas intact into the world. We recapped over dinner. “Tonight, we’re going to get you a multip patient,” my upper level resident promised, “who you can follow from triage and actually deliver.” I was ready.

At midnight, our whole team was in triage, overhearing the details of an incoming patient as she was wheeled in. A 38 year old G5P4 at 36 weeks gestation in spontaneous labor. The numbers said a lot – this was a woman with a well-worn cervix and a smallish baby. My resident turned to me and said, “she’ll be perfect.” I don’t remember actually seeing the patient in triage; I was still filling out her paperwork when I overheard that she was being moved to a room and that I should come quickly.

I caught up to her husband who, up close, I found both strikingly tall and strikingly dark; he wore a blue and white leather Detroit Lions jacket whose white sleeves stood in stark contrast to his skin. He walked with his shoulders slumped forward, as if the leather or life was weighing him down. He had stopped in front of the vacated charge nurse’s desk, looking left and right. “Sir – you can follow
me,” I said with a new assertiveness. I fancied myself deserving of this tone – after all, I was about to deliver his child.

As we entered the room, I imagined that everyone else – the patient, nurse, and my resident – had been awaiting my arrival. I stepped forward into the sleeves of a paper gown while the nurse tied it at the nape of my neck, a ritualized act of teamwork that has always reminded me of a lady in waiting lacing up a queen. The tall father had found a spot to hover, still hunched, between an empty chair and the external monitor, which traced a heartbeat as it swung up and down in accelerations from a baseline of about 115 beats per minute. The mother’s heart rate was also 115.

My resident had already donned a single glove, two fingers lubricated at their tips, and was reaching into the patient’s vagina as I finished my own gloving ritual. “She’s 9, complete, and +1.” Wordlessly, the nurse opened another sterile package containing an amniotomy hook, a plastic device that looks like a knitting needle, and offered it to my resident. I stood at her side, a two person team inside two knees and watched as she inserted the hooked end where her fingers had been. Blindly, she found the bag of fluid, her target, and pierced it.

Her water flushed out, stained but serous. At first I thought it had the brownish-green tint of meconium, but my resident recognized the rusted appearance of stale hemoglobin. “There’s blood in the fluid; it looks like she may have abrupted.” I know now that I was the only one in the room who did not begin to put the pieces together. I did not hear the NICU team called. I did not look back at the monitor and think twice about its synchronized rhythms. I did not see the baby’s father stand straighter in heightened apprehension. I saw only the tufts of hair now parting her labia, which were beginning to take on the stretched, edematous appearance that fated all vulvas, independent of color or parity.

“Push,” my resident said from beside me. “We need you to push now.” Recognizing that I was the other part of her “we,” I placed a blue towel between the fingers of my left hand and her perineum, letting it drape over her anus to maintain a last modicum of her modesty.

She pushed. I pushed back with my right hand as the crown emerged into full view. The head came out quickly, rotating clockwise to face towards the mother’s right inner thigh. The face was my first hint that something was wrong. It looked like the child had been peering eagerly through a pane of glass, features pressed flat and out of symmetry. The eyes looked wider set than natural and the right eyelid was white. My brain began racing through the differential of trisomies or other conditions – Potter’s or perhaps fetal alcohol syndrome – that could cause such anomalies, before I realized that my hands were no longer on the baby. I’d been shoved aside, my resident now pulling legs out. I caught a glimpse of a penis as she handed the dusky purple and white-splotched boy over to the NICU team.

I looked closely at the mother for what shouldn’t have been the first time, but was. Her face was older than suggested even by her advanced maternal age. She had deep creases – no, trenches – that ran in parallel down either side of her face, from the sides of her nose to her chin. Her head lolled over to the right and her brown skin had paled in exhaustion. She didn’t ask any questions and no one
announced the gender. The distant mutterings of the NICU team were totally drowned out by the absence of crying, the absence of congratulations, the unnatural din of silence.

The father was the first to speak. “What’s wrong with my baby?” he asked, eyes darting from person to person. I avoided his gaze by looking toward the pediatricians in the corner, who had the baby and the pink stethoscopes and the suction bulbs and, I assumed, an answer. They were all still hunched over in a furious effort to stir him, to coax out a confirmatory scream.

“Someone needs to call my attending right now,” the neonatology fellow commanded frantically, eyes wide as she looked up from her auscultation, stethoscope still in her ears.

“What’s wrong with my baby?” the dark man repeated, seeming to grow larger. “My baby dead?” It was the first time the question of live or dead had even entered my consciousness. It seemed a simple, naïve concept, and I thought it typical that a parent would jump to such an extreme conclusion. Still, no one answered. “My baby dead?,” he asked louder. The room only quieted in response, which seemed to confirm his worst fear and shattered my understanding of the situation.

“My baby dead,” he said again, with an impossible punctuation that transformed his sentence from a question to a wail. He was right.

“I’m so sorry,” my attending, ungowned, spoke up from somewhere behind me.

“My baby dead, my baby dead!” again and again; the blue and white jacket struggled to keep up with him as he paced and cried between the NICU team and his wife. The former surrounded his son, still and stiff, mouth gaping in a silenced gasp, no longer earning the efforts of the doctors. The latter was still reclined in the lithotomy position, knees up and collapsed outward in a sign of total physical defeat. The spiraled umbilical cord dangled from her open vagina, the weight of a clamp pulled it down toward the floor but was apparently counterbalanced by the amount of placenta still inside her. Bright red blood pooled around it, in sharp contrast to the deadened brown that had heralded her infant’s arrival moments before.

The mother looked out at her now-sizeable audience blankly. Her head spun down towards my resident, who was still perched on a stool between her legs, in response to a final request: “Could you push one more time? We need to deliver the placenta.” We. Closing her eyes, the mother bore down, and the unanchored culprit slid out easily into a blue plastic bin, the last souvenir of the intrauterine calamity in which we’d all become implicated.

The father finally lapped back to the bed and collapsed over his spread-eagle lover. She’d remained notably tearless throughout the whole ordeal, but when his weighty chest covered hers, it shook with the vibrations of their mutual sobs.
In the days following my first delivery, I am overcome with the urge to assign meaning to what transpired that night. Its timing in the story of my medical career seems too uncanny to have happened by accident. I feel conflicting urges to tell no one or to tell everyone, to under- or overemphasize that that child was supposed to be my responsibility, my first real delivery. I meet up with girlfriends who ask expectantly about how much I love Ob-Gyn and I can’t find the words to describe how it has stunned me. It is so much more and so much worse than I could have ever expected. I wonder how many pink, cherub-mouthed, crying babies and flushed, proud parents it would take to outweigh the purples and browns and blues of the family I met that night. I feel certain that no matter how many deliveries I will see during my six-week rotation, it will not be that number.

We discuss the details of the delivery, labeled officially as an “intrauterine fetal demise,” for a couple days on rounds as lab results trickle in; the mother’s urine drug screen was negative and all of her routine labs were normal. The placenta had certainly abrupted but we never discovered exactly why. The tracings on the heart monitor that we’d confused for a fetus’ had simply been the mother’s – their apparent synchrony a morbid forecast and the accelerations simply the yearnings or anxiety of the latter. The baby’s dysmorphic features were most likely the result of being in the same position, presumably pressed up against the wall of the uterus, for several days. But within a week, speculation about the IUFD wanes in favor of conversations about new patients and their preterm labor, placenta increta, or cholestasis. Within a week, I wonder if anyone else remembers.

Time passes, and I watch from the 4th floor window as the foliage falls to catch up with the temperature change. I surprise myself by how quickly I am able to adjust my perspective on the practice of Ob-Gyn. The second through seventh babies that I deliver on subsequent call nights slide out of their multiparous abodes with relative ease and the expected wails. One baby boy is practically laughed out as his young mother valsalvas with each joke her older sister throws at us. The joys of the profession are revealed to me, if belatedly, and I find that these stories are easier to tell. The words to tell them are easier to find, a privilege our language affords the children who are born and die in the prescribed order.

We spend our free time talking in the residents’ lounge about significant others and sharing updates about our families. One of the third year residents gets engaged over Thanksgiving, another’s son is learning to walk, and the intern I worked with on my first call night updates me on her twin’s pregnancy. We trade speculations about our sisters’ choice of names; hers knows she is having a girl, while mine is awaiting a surprise. I talk to Kelsey on the phone, excited by my newfound ability to understand her references to non-stress tests, glucose ranges, and group B strep results that come frequently near term. We laugh at my anecdotes of the babies that deliver themselves and hers of my three-year old nephew. I begin to believe that all is right with the business of babies, that such levity couldn’t possibly coexist with persistent tragedy.
Winter arrives. The cold easily penetrates my light blue scrub pants, the wind lifting them up at my ankles. I climb into the back seat of a fellow student’s car, marking the early, dark start to a Tuesday morning, the 5th of my rotation, the last day of November. We drive long enough for the heat to permeate, my shivering ceases, and my mind settles into the commute. I am calm, looking forward to the day. As I stare out the window and glimpse the hospital, perched atop a hill and thus visible from our exit, I am aware that more than a month has passed since I helped deliver the stillborn son. For the first time since then, I entertain the possibility that perhaps it really was just terrible luck for everyone involved. I permit myself to think that maybe my career path will be a product of choice instead of fate. Maybe that baby’s story is not my cross to bear. But the universe has overheard my thoughts and smirks coyly. Taking its cue, my phone rings.

I see that it’s my dad. He’s an early riser so I’m not surprised that he’s awake but the hour nevertheless signals that something is wrong. I feel certain that he is calling to tell me that my grandfather, 92 years old and recently discharged from the hospital, has passed away. My heart tightens in a practiced attempt at bracing itself.

“Hi, babydoll. Are you at work already?”

“No – almost. I’m on my way there. Why?”

“Kelsey lost her baby last night. She’s being induced today. That’s all we’ve heard so far but I wanted to let you know.”

I have gasped, drawing the attention of my fellow carpoolers. The parts of me left vulnerable to this news now squeeze and numb themselves, reeling from the blow, beginning with my belly. I feel nausea implant.

We enter the hospital in the usual manner – hurrildy, to beat out the cold – but I feel none of the usual rush of relief when I enter into the heated lobby. I move through the rooms on L&D with a gnawing sensation where I imagine my own nulliparous uterus to be. It waxes and wanes, growing stronger when pregnant patients tell me the names or other expectations of the children who will share a birthday with my dead niece or nephew. It lingers, dull, until some expectation of my own surfaces from my subconscious and, meeting reality, promptly dies as well.

In the afternoon, I walk into the lounge as my intern is announcing that her twin sister is being electively induced today at 39 weeks. “Silly girl, she’s just impatient and is tired of being pregnant.” I gather my things from a locker, trying not to attract attention or comparison. Somehow I find the grace to spare her from my misery. I shut my locker, allowing the metal-on-metal to rattle louder than normal, hoping that as I walk out the door, it will drown out any last echoes of happy conversation.

It is my mom who calls me the next morning with an update. Kelsey had stopped feeling the baby move. Doctors at the local hospital couldn’t get a heartbeat. She drove to Burlington with her husband. She was induced successfully. She had her vaginal birth after cesarean. She had a baby girl.
Her name is June Lucille. There was nothing obviously wrong with her or the placenta. In fact, she was beautiful. That is all she knows.

The facts roll around in my brain, organizing, as I’ve trained them to do, into a presentation. A 33 year old G2P1011 at 36 weeks...

Fuck you, universe.

I dream about June that night. I am with Kelsey as she labors, pushing in anger and vengeance and sorrow. I have ample material with which my mind fashions a delivery room. It conjures the scents of iron and sweat, the textures of liquid blood, swollen skin, and sticky vernix. But the silence is most vivid. The inevitable, horrible silence is still fresh in my memory.

I deliver June and announce her gender just as I’d talked to Kelsey about doing, always with a laugh, knowing that of course I couldn’t have such a privilege anywhere but in my dreams.

I hold her first. I see immediately that she has sirenomelia, or so-called “mermaid syndrome,” her legs and organs fused from the waist down. In life, this would have been identified months before on ultrasound, but in my dream, it was a surprise. I feel a calm wash over me as I swaddle her around her fin – we have a reason for her demise. I think my subconscious chooses this fate for June both for its name and its non-negotiable outcome. Mermaids, after all, are ethereal, beautiful creatures that inhabit the imaginations of the innocent. Impossible and incompatible with life, like the birth of summer in the dead of winter.

I place my niece in Kelsey’s arms and step back, watching her gaze at her daughter for the first time. June’s eyes are closed, her cherubic lips pale, and her translucent skin is purpled with bruises from her exit. In this dreamland, as in life, we are all just cells of different colors. Her husband crosses into my field of view, going to join his wife and daughter. Stoic and strong, a modern mountain man, I have never seen my brother-in-law cry. But upon seeing June’s face on Kelsey’s pink chest, he gives a great shudder and collapses over them. His blue and white jacket smothers them all and sobs rack the mount of human sadness.

I leave them there, awakening in a haze of uncertainty. Denial and grief have forged such enticing compromises in my mind. But as I blink my eyes open, I realize that they’re wet, my pillow splotched with real tears.